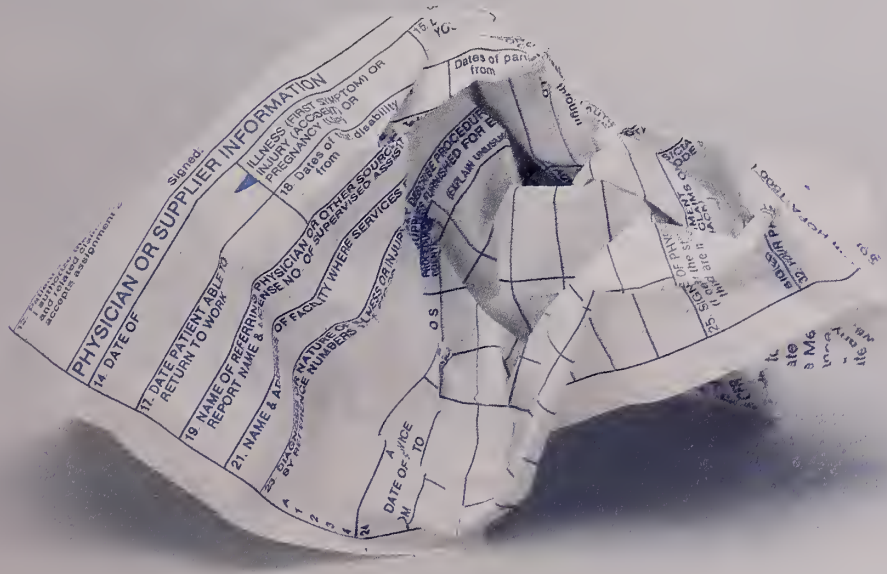
HARVARD MEDICAL
ALUMNI BULLETIN SPRING 1984

Physicians and Money

Grappling with the Issues



Since 1812, The New England Journal of Medicine has played its role in medical circles—reporting the progress of medicine to physicians and medical students throughout the world.

The New England Journal of Medicine

1440 MAIN STREET, WALTHAM, MASSACHUSETTS 02254

HARVARD MEDICAL

ALUMNI BULLETIN / SPRING 1984 / VOL. 58 NO.1

FEATURES

DEPARTMENTS

Cover photograph by Jerry Berndt

INSIDE H.M.A.B.

In 1933, one Douglass V. Brown, Ph.D., came to Harvard Medical School as assistant professor of economics in the Department of Medicine. Two years later, he wrote about his work in an article for the *Bulletin* in which he noted that Harvard "is apparently the only University which has launched such an unorthodox and unpromising venture." He went on to chronicle "difficulties ahead rather than work accomplished," which included the study of payment by insurance and workmen's compensation, care of the indigent, problems of hospitals, certification of specialists, varying incomes for different types of practice, and the supply of physicians.

That same year, young Arthur Pier '39 entered HMS with, he tells us elsewhere in this issue, idealism, eagerness, and enthusiasm. As for the economics of health care, he recalls, "The idea of having to earn a living through medicine hardly entered my head.... If I had known then that my professional overhead expenses would someday exceed $42,000 a year, I might well have run away."

Pier has successfully resisted the impact of medical economics on his practice—but elsewhere times have irrevocably changed for doctors. Brown's list of difficulties ahead is still current close to 50 years later, and is no longer the sole province of economists.

When we first considered taking on the subject of the relationship between money and medicine, we searched for physicians grappling with the issues. We didn't have to look very far. In the HMS-affiliated hospitals we found doctors evaluating their own cost effectiveness. At the school we found a faculty committee taking on the herculean task of evaluating a for-profit corporation's bid to purchase a Harvard teaching hospital. And among the alumni we found innovators, analysts, and philosophers.

In this issue we report on what we've found at HMS, and print the final faculty report on the proposed sale of McLean Hospital. Sankey Williams '70 and James Todd '57 contemplate modern times and recent government regulations; innovators Daniel Doyle '72, Johan Eliot '46, Peter Beoris '76, and Somers Sturgis '31 recount their attempts at meeting the realities of financing and organizing health care head on; and 42 alumni tell us how they pay for their own care. Finally, Arthur Pier reminds us that the point of all this has not changed since he came to HMS with ambition to enter a field "exciting and ever challenging, to do well in it, and, in the process, confer some benefit on mankind."

—Lisa W. Drew

HARVARD MEDICAL
ALUMNI BULLETIN

The *Harvard Medical Alumni Bulletin* is published quarterly at 25 Shattuck Street, Boston, MA 02115.

Third class postage paid at Boston, Massachusetts. Postmaster, send form 3579 to 25 Shattuck Street, Boston, MA 02115. ISSN 0191-7757.

LETTERS

Carrying On

More Legacy of Lewis

"The Life and Legacy of Spencer B. Lewis" in the Fall 1982 *Bulletin* described efforts by Lewis '73 to establish the Zola M. Lewis Family Health Clinic in Grambling, Louisiana, and the American Society of Handicapped Physicians. His wife, Mary, is carrying on his work.

A fund has been established to help finance HMS students or graduates wishing to work in the clinic and learn more about the practice of medicine in a poor rural setting. Contributions to the Harvard Medical Alumni Fund, designated "Specific Purpose for the Spencer Lewis Memorial Fund," will be used as follows:

... providing in whole or in part: (i) modest travel expenses between Boston and Grambling, Louisiana (one way or round trip) and/or (ii) reasonable living expenses while in Grambling, for one or more persons who, while enrolled as a medical student at HMS, or who, during a leave of absence from HMS, or who, after being awarded the degree of M.D. from HMS, works full-time as an assistant, or, if duly licensed to practice medicine, as a physician, for a period of at least 59 consecutive days at the Zola M. Lewis Family Health Clinic, Grambling.

For more information about the American Society of Handicapped Physicians, write to 137 Main Street, Grambling, LA 71245, or call (318) 247-3744.

—*Linda Covell Davis '73*

The Adversary System

First, congratulations on some wonderful stories and poems in the Fall/Winter issue, particularly those by Max Eddy, Lisa Derman, Michael Stewart, and the photographs by the editor!

The particular focus of this letter is the superb article by Tom Gutheil on "Madness, Medicine, and Justice." Of the recent spate of articles—many of them by uninformed persons—on this subject, this is by far the best I have seen. For a non-psychiatrist, non-lawyer, it brings out the important issues for examination.

But there is one flaw in Gutheil's reasoning that must be addressed: the wasteful absurdity of insisting on adversary testimony from expert medical witnesses. He uses as analogy a case concerning a bridge that has collapsed, where, he says, "The engineers must disagree if the trial is to be fair."

But if the bridge is to be repaired, or better bridges built, the engineers *must* "agree" at least in the sense of working together to iron out and reconcile differences, or doing the engineering research necessary to come to a sound plan of action. In insanity defense cases, the need for, and social benefits of, a sound and constructive plan for disposition is too obvious to bear further elaboration.

The difficulty with current procedure is that opposing witnesses are recruited and paid by the two sides. There is a clear, obvious, and compelling conflict of interest in their testimony. Their fees are sometimes exorbitant. Some psychiatrists and physicians make their living by testifying for whichever side will pay them the most. Although Gutheil deals only with psychiatrists testifying in insanity defense cases, this same difficulty applies to all expert witnesses in the American court system.

One cannot help but agree with Gutheil's characterization of the assortment of people that constitutes a jury. That they might distinguish amongst witnesses of good faith would be asking a lot! But in point of fact, in our "system" as extolled by Gutheil, one or both witnesses is simply saying what he or she is paid to say. The witness overemphasizes and exaggerates things for "his or her side" that, in the witness's own intellectual honesty, might not appeal to him or her at all, and completely confuse the jury.

Gutheil uses the word "patientocentric" to mean judgments in the interest of the patient. We should recall that the definition of a professional is "a person who values service to his client above his own personal gain." The client is the patient—and, in court, society as a whole. To set aside this highest of value judgments to impress a jury (in return for a fat fee) makes a mockery of the Hippocratic Oath and suggests that, for court witnesses, it should be renamed the "Hypocritic" Oath.

The solution is simply that expert witnesses should be hired and paid by the court rather than by the two adversaries. They should speak as "friends of the court" and operate as expert assistants to clarity of thought, not as hired guns. This role for experts can now be seen, I understand, in courts in Great Britain and in some specialized court procedures in this country.

In such a system, psychiatric witnesses can examine *all* the evidence and give to the court whatever interpretation they honestly adopt. Following such truly neutral expert testimony, the two adversarial lawyers can tear it apart, apply it, or distort it in any way they wish, but both the expert opinion itself and its distortions by adversaries will be wide open to the jury.

It is quite true that the judicial system exists on an adversary basis and that the body of law is built up on a case-by-case experiential record. But it is not true that expert witnesses

must be paid for, biased by, and servile to, the interest of one side or the other, rather than to the science, skills, and body of knowledge of their profession.

—*Francis D. Moore '39*

Thomas G. Gutheil '67 replies: I am very grateful to Dr. Moore for his praise of my article, and for his comments. With his characteristic lucidity and energy, he has provided me an opportunity to elaborate on some significant points.

There is enormous resistance on the part of judges (including Supreme Court justices) and lawyers to changing the adversary system. It is as imbued into legal bones as *primum non nocere* is into medical ones. Yet in a limited number of cases—including child custody cases—the courts have tried bringing in individual experts, or teams of experts, to work for the court itself instead of one of the two parties.

Our Program in Psychiatry and the Law at Massachusetts Mental Health Center is trying to foster the use of an attorney and a forensic psychiatrist to serve as a combined *guardian ad litem* (special investigator for the court) in cases of the right to refuse treatment, allowing for more clinical input in these decisions.

Compared to my colleagues I am perhaps a veritable Pollyanna in this respect, but I believe the adversary system can work in regard to expert witnesses—even though most of us are more familiar with the abuse of the system than its ethical functioning

As I indicated in my article, it is possible to have two witnesses of equal integrity on opposite sides of the case, although in practice it is more common to see the Harvard professor versus the hired gun. The fact that some expert witnesses exaggerate, lie, or slavishly say what they have been coached to say, does not inherently refute the value that even such a witness might have in balancing the case for the jury. To put it another way, because some lawyers are incompetent doesn't mean that we should necessarily do away with all lawyers, no matter what Shakespeare said.

Regarding Dr. Moore's penultimate paragraph, where he speaks of "truly expert testimony": the courts simply don't believe such testimony can be supplied. In order to give both sides a chance to squeeze the issues out in examination and cross-examination, it is necessary to have two sides of the case, hence, two witnesses.

The fee question is a separate issue. Anyone who withstands the time, stress, and burden of courtroom preparation and tolerance of examination and cross-examination in court, with the resulting disruption of schedule, is, in my view, entitled to a reasonable expert fee.

I don't mean that we should approve of our colleagues prostituting their opinions by selling their testimony. I firmly believe that it is possible to give reliable expert testimony without "selling out." I suggest that we increase the sophistication of expert witnesses by improving their skills and knowledge of forensic medicine, a relatively underserved and novel area. The courts might well benefit from the input of so distinguished a clinician as Dr. Moore if he, or others like him, could learn to handle the technical difficulties of coping with lawyers in and out of court.

None of the above is intended to counter the need for and appropriateness of professional *amicus* briefs. I have contributed to a number of these myself, and they are occasionally quite helpful to the court.

I doubt that I have convinced Dr. Moore, but again I am grateful for his letter. The insanity defense is a troubling issue, which will continue to confuse and outrage many citizens within and without the medical and judicial systems.

A New Malignancy?

In recent issues of the *Bulletin*, there seems to be a baffling new gush of polarized opinion on the

topic of nuclear weapons. It is puzzling that so many medically astute writers address this topic, and yet all of them fail to appreciate the fundamental principles of disease that are involved.

It is well known, for example, that the disease we call cancer kills almost 400,000 people a year in the United States. At this rate, about 20 million people will die of cancer in the next 50 years. At present, surgery, chemotherapy, and radiation therapy offer hope to millions who might otherwise perish from this horrible affliction. To be sure, none of the current therapies is benign, but all are better than dying of cancer, and few medical professionals would recommend that the disease be treated by eliminating surgery, chemotherapy, and radiation therapy.

Since 1918, a new disease of unparalleled malignancy has started to ravage the world. As Nobel laureate Alexander Solzhenitsyn reveals in *The Gulag Archipelago,* this disease killed an estimated 20 million people in its first 45 years of existence. This "disease," of course, is the Soviet variety of communism, and the underlying pathophysiology is death by starvation in forced labor camps. Since the 1940s, the most effective "treatment" preventing the spread of this disease has been an overwhelming American superiority in defensive weapons, particularly nuclear weapons.

In recent years, a growing obsession with the possible side effects of nuclear weapons has overshadowed the threat of this new Soviet disease. Now the anti-nuclear obsession has apparently seized so many people in medicine that their concern has started to flood the pages of the *Bulletin.* In flawless unison, they call for the immediate and permanent disposal of all nuclear weapons.

Perhaps cancer should be treated in similar fashion. All proven, effective forms of cancer treatment with undesirable side effects could be discarded as part of a negotiated nonaggression pact with malignant cells. This tactic would be no less effective than negotiating nuclear disarmament with the Soviet Union, which has violated all 26 of its treaties with the United States thus far.

However, until that mythical day when negotiations with cancer cells and the Soviet empire are likely to succeed, it seems wiser to use remedies that are of known effectiveness against a known threat. Any other approach, either in medicine or in military strategy, constitutes utter quackery.

—Edward B. Elmer '83

Note: In reply, the editor cannot fail to quote James Thurber: "This is logic as I know and use it." How do you apply logic to the unthinkable?

Before the Race

I touched only lightly upon my travels to Newfoundland in my article "The Race" in the Spring 1983 *Bulletin.* It was on those choppy phosphorescent waters, among those cliffs, and in those snug harbors that I found a people seeking a physician. In my memories, a small sweet bush calls me back to my youth among the fishermen. A poem from those memories: "Boys' Love": This is boys' love/The morning sun and the early dew that rises make the scent ever sweeter./ Boys' love./The scent will not go away.

—Albert D. Anderson '52

Kudos for the Bulletin

Congratulations on the Fall/Winter issue of the *Bulletin*! It is by far the best and most absorbing one ever.

—Guy S. Hayes '39

The *Bulletin* did a beautiful job of describing Max Eddy and printing his stories in the Fall/Winter 1983 issue. Altogether, that was a fascinating edition.

—George "Barney" Crile Jr. '33

Many thanks for Gordon Scannell's obituary of Myles P. Baker. Myles, who had been my section leader in medicine, was my lifelong hero. The obituary captured much that I would have liked to say about him.

—Herbert C. Moffitt '41

The editors welcome letters from readers, particularly in regard to articles published recently in the Harvard Medical Alumni Bulletin. *Letters should be brief, double spaced, submitted in duplicate, and marked "for publication." Not all letters can be used; those accepted will become the property of the* HMAB *and may be edited, although we are unable to provide pre-publication proofs.*

Wanted: Physician/Bicyclist

Fifty Harvard undergraduates planning an eight-week transcontinental bicycle trip from Boston to the L.A. Olympics, June 8-August 4, seek a physician, physician's assistant, or registered nurse to accompany them. The purpose of this group, called *The Riders for Life*, is to raise funds for Oxfam America, the worldwide hunger-relief organization. If interested in all or half of this expense-paid trip, contact Stacie Wong at (617) 876-6449, or Michael Agliardo at (617) 498-3158.

PULSE

Genesis of a Genetics Degree

In December 1983, the Division of Medical Sciences and the university's Faculty of Arts and Sciences spawned their 11th offspring, a Ph.D. program in genetics. The infant and its sibling, virology (born February 1983), are the first new arrivals in nearly a decade. Joint custody arrangements are the same as for all graduate courses of study at HMS: the division will administer the program and FAS will grant degrees.

The genetics degree will fulfill a need created by a blurring of traditional boundaries in the biological sciences, according to Harold Amos, chair of the division. The proposal to FAS reads in part: "From the discovery of the three-dimensional structure of DNA in 1953 to the more recent development of recombinant DNA technology, attention has centered on the identification of unifying principles that cut across a variety of disciplines and explain activity from the level of the gene to the evolution of new species."

Genesis of the graduate study coincides with the 75th anniversary of the Division of Medical Sciences, which will be celebrated in the spring and fall of 1984. Distinguished guests and graduates of the division's programs—many of whom have attained national and international renown—will be invited to participate. □

JUDITH BRENNING

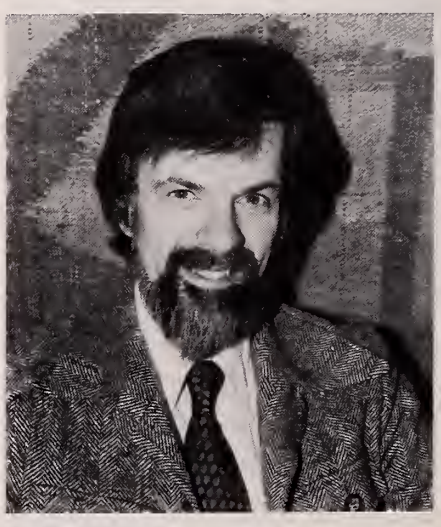
Division of Medical Sciences chair Harold Amos and executive officer Jean MacQuiddy (standing and seated, far right) with doctoral students, seated left to right: Dwayne Simmons, Virginia Miller, Sheridan Swope, Eric Gulve, Shawn Fields-Berry: standing: Nancy Johnson, Paul Albert, Bill Paganelli.

New Mallinckrodt Chair

The first Edward Mallinckrodt Jr. Professorship of Pharmacology has been awarded to Keith W. Miller, who for 15 years has been investigating how anesthetics work—first at Oxford and then, since 1971, at Massachusetts General Hospital.

The new professorship was established by the Edward Mallinckrodt Jr. Foundation and the MGH Department of Anesthesia. Philanthropist Edward Mallinckrodt Jr. (1878-1967), Harvard College 1900, first became interested in the department during the 1946 Ether Centenary, when he struck up a friendship with its chairman, Henry K.U. Beecher '32.

In past years, Mallinckrodt and the foundation have established an endowed chair in immunology at the



JUDITH BRENNING

Keith W. Miller

Quadrangle and a professorship of medicine at New England Deaconess Hospital. The foundation also supported construction of the Beecher Memorial Laboratories at MGH in

EDWYN PORTRAIT

Edward Mallinckrodt Jr.

1977. Several other professorships at HMS and elsewhere in the university bear the Mallinckrodt family name.

Miller's investigation of anesthesia is based on the critical volume hypothesis he and colleagues developed at Oxford, which indicates that unconsciousness results when enough molecules of anesthetic dissolve in the lipid bilayer of nerve-cell membranes to bring about a critical increase in membrane volume. Miller postulates that when the lipid bilayer expands, its normally well-aligned hydrocarbon chains are disordered. The disorder changes the way the protein "gatekeepers" regulate the flow of ions that ordinarily excite the cell. □

Stoneman Chair to Paulin

In "an expression of our strong commitment to the academic excellence of Harvard Medical School and to the high achievements in research and patient care at Beth Israel Hospital," Mr. and Mrs. Sidney Stoneman of Boston recently endowed a new chair, to "enhance the goals of both institutions." BIH's radiologist-in-chief, Sven Paulin, also professor of radiology, has been named the first Miriam H. Stoneman Professor.

The Stonemans have strong ties to both BIH and Harvard University. Mrs. Stoneman, for whom the chair is named, is a graduate of Radcliffe College. A trustee of BIH, she has long served the hospital as a volunteer, devoting special attention to anxieties of emergency patients and their families.

Mr. Stoneman, a graduate of Harvard Law School, was president of BIH from 1970-73. He has been a trustee since 1962, has served as chair of BIH's Executive Committee, and for the past decade has been chair of the Board of Managers of Endowment Funds.

Dr. Paulin first became known for his study of coronary circulation at the University of Göteborg in his native Sweden. In 1964 he developed a less invasive technique for coronary arteriography which was widely adopted throughout Europe. Rather than place the catheter directly into the coronary artery, the usual technique of choice in the United States, he sprayed contrast dye at the root of the aorta to fill the artery.

Since coming to Boston 14 years ago, Paulin has focused on identifying the side effects of contrast agents

ELLEN BARLOW

Sven Paulin

and the complications of angiographic procedures—finding, for example, that not only high but also very low levels of sodium can trigger arrhythmias. His group was one of the first to introduce routine temporary heparinization to avoid clotting at the insertion of a catheter, a practice that has been widely adopted. In 1974, anticipating the impact of the computer age, Paulin and associate Tamas Sandor developed high-precision densitrometry for the analysis of coronary arteriograms. Paulin's latest research involves using nuclear magnetic resonance spectroscopy to determine contrast-media toxicity on a cellular level.

Recently Paulin has also worked on updating his alternative method of arteriography. □

New Settings for MMHC Clients

In recent months Massachusetts Mental Health Center has opened two unique facilities for its clients: a supervised apartment building on nearby Mission Hill, and a group house in Jamaica Plain. Funded by the U.S. Department of Housing and Urban Development to demonstrate innovative community housing for the mentally handicapped, they are the first such homes to be owned and renovated in MMHC's name. Mental Health Programs, Inc., a non-profit corporation affiliated with MMHC, is the recipient of the federal subsidies, which take the form of low-cost mortgages.

Helping patients out of the institution and into the community has been among the most significant trends in care of the mentally ill over the past two decades, fostered in Massachusetts by the 1966 Community Mental Health Act. At MMHC a system of continuing care provides treatment to clients within the center; in MMHC-affiliated nursing, group, and family care homes; and in independent living apartments. This system has thus far been at the mercy of the tight Boston area rental market, often relying on the generosity and concern of landlords.

With its unprecedented control over its two new facilities, MMHC has been able to specifically plan for particular populations of patients, plugging gaps in its program of continuing care. The Mission Hill facility,

JUDITH BRENNING

Miles F. Shore '54, superintendent of Massachusetts Mental Health Center

which opened in June 1983, provides a setting for independence with some staff and peer support. In addition to their own apartments, the six tenants have common space for meetings and other activities. MMHC staff visit daily.

The new group house serves more seriously ill clients. It provides private bedrooms and shared cooking, dining, and recreation quarters for 11 residents, who participate in treatment programs outside the house on weekdays. MMHC staff are on site 24 hours a day.

Governor Michael Dukakis was among those celebrating the October opening of the Jamaica Plain residence. "This house is really what we meant by community mental health," he remarked, referring to the 1966 act. "We will do what we can to support this and support you in your efforts to help people achieve the best that is in them," he added.

Research staff at MMHC are currently studying new systems of care finely tuned to the level of individual patients' needs. □

Alumni Council

Beginning with this issue, the *Bulletin* will regularly report on the meetings of the council of the Harvard Medical Alumni Association.

The association serves as the voice of the alumni, and as a partner for the dean and his staff in promoting the aims of Harvard Medical School. The council meets each fall, winter, and Alumni Week, in accordance with the constitution, to "promote the interest of Harvard Medical School in advancing medical education and improving the care of the sick," and to "promote acquaintance and good fellowship for the mutual benefit of alumni, their community and the School." Members of the council are listed on the *Bulletin* masthead.

The association has three major components: alumni relations, the *Alumni Bulletin*, and the Alumni Fund. All three functions were formerly administered by one individual. But with expansion of activities, each service now has a leader: Perry J. Culver '41, director of alumni relations; J. Gordon Scannell '40, editor of the *Bulletin*, and Carl W. Walter '32, chairman of the Alumni Fund.

At the fall 1983 meeting of the council, topics of discussion included admissions policy, the Oliver Wendell Holmes Society (the New Pathway program), contact with the Harvard Alumni Association, and ways of increasing alumni visibility with students.

The major announcement was that Perry Culver and Carl Walter will step down from their respective positions as director of alumni relations and chairman of the Alumni Fund as of June 1984, each after over a decade of service. The council appointed nominating committees for their successors, chaired by Grant Rodkey '43A and Robert Lawrence '64. Alumni are encouraged to submit names to Drs. Rodkey (for director of alumni relations) and Lawrence (for chairman of the Alumni Fund) through the Alumni Office.

The high point of the meeting was a multi-media exhibition covering the ceremonies and programs of the HMS Bicentennial. Complete with slides of fireworks and snips of television programs, the presentation was made by Lillian Blacker, director of the Medical Area News Office. Blacker had recently won a special citation from the Association of American Medical Colleges Group on Public Affairs for her work on the Bicentennial.

Among its other functions for the Bicentennial, the News Office arranged for professional videotaping of the Convocation; set up sequences for "Chronicle," a local television magazine show; commissioned a play on Oliver Wendell Holmes and coordinated an evening of dinners and celebrations before the performance; published a quarterly *Bicentennial Report*; and featured special Bicentennial articles in *Focus*, the medical area weekly newsletter.

Admissions Policy

Next on the agenda were reports on admissions policy from Gertrude (June) Murray '54, a non-faculty member of the Admissions Committee; Gerald Foster '51, director of admissions; and Dan Federman '53, dean for students and alumni.

The council was first presented with some national figures. The total number of applicants is falling nationwide, as is the number of black applicants. The number of female, Chicano, and Oriental applicants is rising. HMS statistics reflect these trends. There is no shortage of qualified applicants at HMS: last year 3,200 applications were made for the 165-member class.

Each application is reviewed individually by a member of the Admissions Committee. Gerald Foster commented that alumni had happily and effectively participated in four regional interview programs this year. All applicants are offered tours of the school conducted by students, and each applicant granted an interview receives a recruiting and welcoming letter from a current student.

HMS has the best record of all American medical schools in enrolling those applicants it accepts. Those who turn down HMS apparently do so mainly for financial reasons, and usually attend state schools, which have lower tuition and more grants-in-aid.

The council asked for clarification of the admissions policies regarding alumni offspring. Foster outlined the procedures, which ensure that all alumni offspring are given interviews, and explained that he personally reviews all their applications. If alumni offspring are put on the waiting list, they are the first taken off for acceptance.

Oliver Wendell Holmes Society

Dean Federman gave a report on the Oliver Wendell Holmes Society, the New Pathway through medical education. Since it was first proposed in May 1982, the concept has undergone considerable revision and development. As it now stands, the society will be a five-year program with revised medical education content for a group of 25 students who will enter in September 1985.

The program will include four years of medical school and the first post-graduate year. There will be problem-based teaching, and the fifth year will be flexible and oriented to clinical responsibility. Students should be able to go directly from this program to the "non-bedded" specialty residency programs of ophthalmology, pathology, radiology, and psychiatry, and to the second post-graduate year of medicine, surgery, pediatrics, and family medicine.

A steering committee has been meeting every two weeks to complete the plan, which should be ready for review and approval by the Curriculum Committee and the faculty by spring 1984.

Harvard Alumni Association
To keep in touch with other components of the university, the Alumni Council appoints a representative to the Harvard Alumni Association. John R. Brooks '43B, who has been the representative for the past four years, reported that the group has recently attended programs at HMS and the Kennedy School; the Law and Divinity schools will follow.

Brooks also reported that presidents of the alumni associations of the graduate schools are considering holding annual conferences.

Increasing Alumni Visibility with the Students
Suggestions for increasing alumni visibility centered around the five academic societies, in which alumni have been invited to participate on a rotating basis. Other suggestions included student/alumni committees, and alumni-sponsored lectures by distinguished guests.

• • •

In the past few years, the council has concentrated on preparations for the Bicentennial, particularly the 12 regional celebrations and the 1982 and 1983 Alumni Days, and has received reports on the progress of all other Bicentennial events.

The dean and the council recognize and value the special talents and expertise of non-faculty alumni, and are eager to have them participate in as many faculty committees as possible. The council has nominated non-faculty alumni to several HMS standing committees, including admissions, educational evaluation, curriculum, and library. These representatives regularly give progress reports to the council. The dean and the council have profited from the reports, and have incorporated many of their suggestions into current policy.

Two years ago the council initiated the annual Prize Essay Contest for residents and research fellows at Harvard teaching hospitals. The contest has thus far been judged by Joseph S. Barr '60, Hope L. Druckman '76, Albert Mendeloff '42, and Stephanie Pincus '68 (see Pulse, Summer 1983).

The Alumni Survey Committee has completed two investigations since the report on premedical education by Edward H. Ahrens Jr. '41 and Carlton M. Akins '66, under the chairmanship of Henry W. Vaillant '62, published in the Fall 1981 *Bulletin*.

In October 1981 the Survey Committee reported to the council on core clinical clerkships, emphasizing the importance of preparation and orientation for the clerkships and careful and clear evaluation of student work. Three months later, James Adelstein '53, dean for academic affairs, presented to the council changes in the clerkships proposed by the Curriculum Committee under the chairmanship of Norman Geschwind '51. The proposals included introducing competency examinations before the clerkships, increasing the core clerkship requirements from eight to 12 months, and making concentration programs optional.

Last year Carlton Akins assumed chairmanship of the Survey Committee, and delivered the committee's assessment of HMS student housing to the council at its June meeting. The report documented the lack of safe, convenient, attractive, and affordable housing. Its recommendations include extending the hours of the Vanderbilt Hall housing office, ensuring access of married medical students to graduate married housing in Cambridge, and undertaking a feasibility study of converting Vanderbilt Hall to apartments or otherwise supplying an apartment-like facility to HMS students. □

Warren Museum curatorial associate David Gunner with Tuli G. Ushakoff

The Bionic Man

A hollow-fiber kidney and an early version of a pacemaker grace the new exhibit on bionics at the Warren Anatomical Museum in the upper reaches of Building A. Material for the exhibit and a fund to further the work of the museum were donated by Mrs. Tuli G. Ushakoff, widow of biomedical engineer Alexis E. Ushakoff, Harvard College '29. As chief scientist for the Cordis Corporation, Mr. Ushakoff invented key aspects of both devices. The museum is now soliciting additional material to augment the exhibit.

The Warren Museum is entirely dependent upon gifts to increase its collection of instruments, specimens, and memorabilia illustrating the history of medicine and medical technology. Recent donations include several barber-surgeon's bowls and pap-feeding cups, from John H. Monroe '47; a late-19th-century examining chair that converts to an examining table, from John Adams Jr. '29; and an early brass binocular microscope, from Dr. and Mrs. Lester M. Barron.

The collection was started at the turn of the 18th century by John Collins Warren, son of John Warren, one of the founders of the school. Contributions from medical professionals of three centuries are included among the more than 15,000 cataloged items. □

Harvard Doctors on the Fiscal Frontier

Charting New Territory

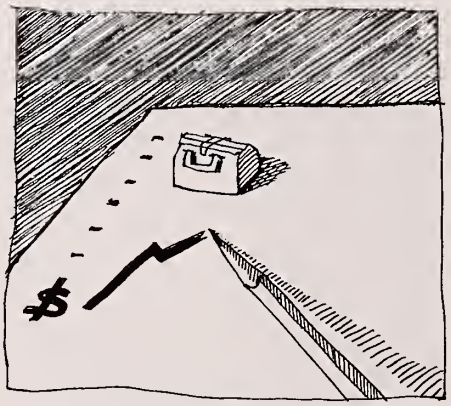
by Lisa W. Drew

This is a look at what is being learned, taught, and practiced at Harvard Medical School and its affiliated teaching hospitals in response to the crunch on the health-care dollar. Although the setting is institutional—as that crunch is thus far being felt most directly by hospitals—the subject is the physician.

Some of the most creative thought in medical administration today—from the for-profit corporations to the city hospitals—has to do with influencing, informing, and ultimately changing the behavior of practicing physicians. It has become abundantly clear to observers that one person makes the decision to admit to the hospital and then link the patient with the tests, drugs, and technology—a decision that boils down, for economists, to spending or not spending. That person is the clinician, who may not care at all about the financing of health care, only that he or she is able to practice medicine.

"If you have people who don't want to come to class," points out Ronald Arky, chief of medicine at Mt. Auburn Hospital, "it's hard to begin teaching the lesson."

Why should physicians want to come to class? In 1985 they may find the hospital Medicare reimbursement scheme now operating in 46 states covering them as well—and insurance companies may follow Medicare's lead (see Sankey Williams and James Todd pieces in this issue). Some patients may soon be eligible for Medicaid only if their care is provided according to tough PSRO guidelines. And analysts have predicted hard times for the relationship between physicians and hospitals—particularly where communication breaks down. In his *Bulletin* article (Spring 1983) on hospital finance, Mitchell Rabkin '55, president of Beth Israel Hospital, quoted economist Victor Fuchs: "The most significant battle line emerging is between a fiercely independent profession and a management structure that seeks to gain firmer control over what doctors do."(*Health Affairs*, Summer 1982).



Some of the most creative thought in medical administration today has to do with changing the behavior of practicing physicians.

Is that battle line emerging at Harvard? If so, it is necessarily blurred, as those studying and advocating change are physicians themselves. In answer to a different question, about the current climate at BIH, Rabkin recently said, "A couple of years ago I could go to the dining room for lunch and look forward to joining a group of doctors to get caught up on the clinical side. Now their conversation is about finance and administration before I even get there."

At Mt. Auburn Hospital, Arky comments, "I feel, frankly, that the situation will be more crucial in time in non-teaching hospitals that don't have house staff. In the teaching hospitals we have a means to control behavior, in our educational mission, that the private hospital lacks."

At the student level, there's a new twist these days to one of the routine jokes: "What do you call an HMS student who graduates last in his or her class?" it goes. "Doctor," is the punchline. Now there's a second answer: "And unemployed."

With the exception of a period of activism in the late '60s, student interest in the economics of health care has never been particularly high. "Asking us how we'll run our practices or bill our patients is like asking newlyweds how they'll manage 2 AM feedings," comments Erik Gaensler '84. "We're just not there yet."

But they do have a growing awareness of the issues. Although three students tell this writer, at lunch in Vanderbilt Hall, that they're "more worried about getting potassium values than about the financing of health care," they talk about subspecialty "zone wars" (one of their classmates is reportedly going into pediatric

ILLUSTRATION BY KATHERINE MAHONEY

neurologic oncology), express opinions on for-profit medicine, and worry about a patient who could be treated with less expensive antibiotics than prescribed.

They also bring up one anxiety that's a striking sign of the times: the HMS student in the joke will be unemployed, they explain, because he or she should have stayed near the top of the class in order to get a good residency—in order to get into a good group practice. The competition they've felt since their premed status isn't relieved anymore with acceptance to medical school.

How do the students become informed about the changing economics of health care? They might take a course from medical economist Rashi Fein, Ph.D., which covers the issues of "physician supply; role of HMOs, Medicare and Medicaid financing, cost containment efforts, competition; effects of changes in resources, reimbursement, and conditions of practice on patient and physician behavior; and comparison of patterns in U.S. and other countries."

Subjects related to the financing of medicine are gradually making their way into the HMS course catalog. In the past few years three of the primary-care listings have added considerations of cost-effectiveness and resource allocation to their descriptions. Three courses with "economics" in their titles are listed in the Health Sciences and Technology section. One of those is held on the HMS campus: "Topics in the Economics of Health Care," taught by Allan Detsky '78, who started the class as a first-year student. He now commutes from Canada to Boston each January to teach the course.

Barbara McNeil '66 has recently been appointed professor of clinical epidemiology and radiology, and will be developing offerings in the Department of Preventive Medicine and Clinical Epidemiology. Her aim: "to train students in analytic methods for studying diagnostic and therapeutic processes—in order to improve patient care, and raise awareness of use of health resources."

Students can also take in-depth health policy courses at Harvard School of Public Health, or in the Division of Health Policy Research and Education, a joint venture of Harvard's schools of medicine, public health, and government. But most with an interest in the subject take Rashi Fein's class, which has expanded this spring from one to three credits. For more on his course and the student perspective, see page 13.

The nature of the new hospital finance beast has two determining factors: a radical change in the workings of hospital reimbursement, and an unprecedented competition for patients.

Reimbursement is almost a misnomer for the new prospective payment scheme now setting rates in advance for Medicare patients in 46 states. Hospitals are no longer paid back for costs incurred for those cases, but are instead given a fixed sum, determined by diagnosis related groups (DRGs). The other four states (Massachusetts, New York, Maryland, and New Jersey) have instituted trial variations on the cost-containment theme.

In the Harvard-affiliated teaching hospitals, under the state's Chapter 372 mandate, there's a limit on financial activity, determined in advance for each by a maximum allowable cost formula. Hospitals can save by keeping costs within the formula, and are at risk for going outside it, where they may be paid only a fraction of every dollar.

Restricting the amount that can be charged—whether with a cap on spending or with set figures—is nothing short of a revolution in the financing of health care. The very services that might have helped keep the hospital afloat less than two years ago now only add to costs which must be kept within limits. "Two years ago," recalls Anthony Komaroff, deputy director of the Center for Cost-Effective Care (CCC) at Brigham and Women's Hospital, "physicians weren't doing the hospital a favor if they restricted test ordering."

Barbara McNeil of the Center for Cost-Effective Care

PHOTO BY ED MALITSKY

Barbara McNeil, director of the CCC, supplies a basic axiom: "If government and society have decided they're not willing to support the rate of increase in the cost of health care, but the rate of innovation continues to grow, then the only way to incorporate advances is to be more efficient."

In the second factor, the new competition, the players include almost every form of health-care delivery, from municipal hospitals to private practices. The prize is the paying or well-insured patient—preferably young, without too many complications. The complex reasons for the competition, intensified by the new reimbursement regulations, include the rapid growth of for-profit corporate medicine, the advent of alternatives such as HMOs and PPOs, a surplus of hospital beds, and the highest physician/patient ratio ever.

The effect on teaching hospitals threatens to be critical. The new regulations may eliminate cost shifting, one of the basic survival tactics for caring for the indigent patient, which involves charging others enough to fill the gap created by those who can't pay. And entrepreneurs are finding it profitable to offer only those services, such as outpatient facilities for minor surgery, that guarantee a return, thus robbing the hospitals of their money-making potential. The fear is that teaching and municipal hospitals could become large, slow-moving dumping grounds for the most expensive, least profitable cases.

In the *New England Journal of Medicine* recently, Robert Petersdorf, former president of BWH, bluntly wrote of university hospitals, "unless they develop a patient base to meet their tertiary-care needs, their practices will wither on the vine."

The response of the Harvard hospitals has been to investigate ways to shore up and add to their primary-care practices and facilities. Each of the large hospitals, for example, is considering reaching out in satellite fashion. "We're asking," comments

Mitchell Rabkin, "if you can do that while providing high-quality care. Can you maintain high standards and compete with the for-profit 'urgicenters'?"

"Any hospital-based primary-care practice," points out Komaroff, "is by definition competing with the for-profit outpatient centers, which do answer a need for accessible care. The potential downside of those places is that they might attract physicians of unknown quality, and might end up doing only those things that run up the bill. Brigham and Women's certainly doesn't want to emulate that."

The fear is that teaching hospitals could become large, slow-moving dumping grounds for the most expensive, least profitable cases.

The new turn hospital finance has taken and those trying to puzzle it out have been likened to the tale of the elephant and the blind men, in which each man draws a different conclusion about elephants, based on which part of the animal he touches. The story ends with a wise rajah explaining that the elephant is the sum of its parts.

In the Harvard-affiliated teaching hospitals, there is no rajah with the vision the blind men lack, and there are plenty of ears, tails, and sides to occupy those who are trying to come to terms with the financing of health care.

Each of the hospitals has access to the elephant, and each is thoroughly exploring it. The general strategies are common to all. Among the most visible of those projects that have direct implications for physicians:

■ At Brigham and Women's Hospital, the Center for Cost-Effective Care is developing sophisticated data reporting systems that break down the hospital's costs in a number of ways, including costs incurred per physician. "Everyone's expectation," says director McNeil, "is that the research will result in real management tools once the system is debugged."

Management strategies will be determined by the hospital administration, linked to the CCC and the clinical side by Komaroff, also hospital vice president for management systems, and chief of the division of general medicine and primary care. It is his responsibility to "integrate the most successful projects of the center into the daily workings of the hospital." Komaroff sees the question of feeding data back to physicians about their practice patterns as "maybe our most special issue—and one with the potentially largest impact."

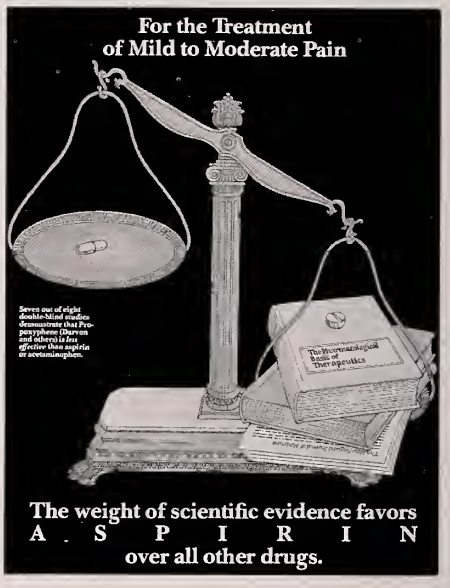
In October 1983 the CCC sponsored a conference titled "Relating Clinical Practice and Hospital Administration" which drew 230 top hospital administrators from around the country. The center also sponsors a monthly seminar series, which has featured speakers ranging from health-policy writer John Iglehart on DRGs, to David Jones, chairman of the board of Humana Incorporated, on for-profit management strategies for hospitals.

The CCC was established three years ago with a grant from the Commonwealth Fund of New York, and now receives funding from the Blue Cross/Massachusetts Hospital Association Fund for Cooperative Innovation.

■ At Beth Israel Hospital, Jerry Avorn '73 and colleague Stephen Soumerai are instituting a program to educate staff about prescribing drugs. They have spent a year creating a system which, among other capabilities, can maintain "ongoing surveillance of patterns of drug utilization," identify those services and physicians "involved in the highest levels of potentially inappropriate drug utilization," and "determine the mechanisms, perceptions, and attitudes that underlie such prescribing, as a prelude to attempting to change them." Funding for this project comes from the BC/MHA Fund for Cooperative Innovation.

Avorn and others have shown in studies that physicians are more influenced by commercial messages about drugs than they believe themselves to be. To combat this factor and others influencing prescribing behavior, Avorn and Soumerai have created the "unadvertisement," which conveys intellectually rigorous information while making use of the commercial approach. Other strategies include the use of "undetailers" to educate house officers about optimal drug use, and the implementation of a new hospital-wide antibiotic ordering form with inappropriate prescribing intervals blocked out, and relevant drug information printed on the form.

In this effort, as in many others that come under the heading "cost containment," the intervention should result in better medicine. Soumerai cites a recent study (*NEJM*, 12 March 1981), in which investigators from Boston University Medical Center found an iatrogenic illness incidence of 36 percent in 815 consecutive patients on a general medicine service. Of that 36 percent, half were caused by drugs—and of those complications, six to nine percent were major or severe.



An early "unadvertisement." The material Avorn and Soumerai are now developing will emphasize findings from clinical literature in greater detail.

■ At Massachusetts General Hospital, which has perhaps the most active outpatient service of any teaching hospital in the country (up to 800,000 encounters a year), ambulatory care has been of particular concern. George Baker '57, associate

general director for medical affairs, sees one of the hospital's tasks to be "educating the staff to a specific problem: the short stay that could be handled on an outpatient basis."

Last year, Robert Buchanan, MGH general director, established an ad hoc Committee on Ambulatory Care, headed by Walter Guralnick, former director of the Ambulatory Care Center, currently director of the operating rooms. "To expand the present base of ambulatory care," comments Guralnick, "will require unprecedented accommodation of the medical staff and administration to each other." Buchanan's charge: "Undertake a comprehensive review of the present status of ambulatory services and recommend a course for the future." In January of this year Guralnick organized a two-day retreat for the 17-member committee and roughly 30 other key staff and administrators.

At the retreat, participants attended talks and brainstorming sessions, and formed teams to write papers on the feasibility of establishing various new forms of outpatient systems at MGH—such as a health maintenance organization (HMO), preferred provider organization (PPO), or satellite facilities. The ad hoc committee will deliver final recommendations to Buchanan by June of this year.

"Anyone in hospital administration who thinks of long-range planning in terms of more than two or three years is kidding himself," points out Guralnick. "Hospitals have to get their ducks lined up soon, or they'll be overwhelmed."

▪ Also at MGH, the Medical Practices Evaluation Unit has recently received funding from the BC/MHA Fund for Cooperative Innovation to study use of resources in the coronary ICU. The unit—established six years ago with a grant from the Millbank Memorial Fund, and then funded by the John A. Hartford and Robert Wood Johnson foundations—has been creating a data base on ICU resource allocation at MGH. One example of its work thus far is the development of criteria for evaluating length of ICU monitoring periods of patients recovering from myocardial infarctions.

One of the goals of the new project—jointly administered by George Thibault '69, director of the ICU and assistant chief of medicine, and Al Mulley '74, unit chief of general medicine—is to undertake an educational program in the hospital.

"What's different about our work," says Mulley, "is that we're clinically involved on a day-to-day basis. If costs are to be cut without sacrificing quality, then we need better, workable clinical information." He and Thibault plan to produce a handbook, on paper and in the computer, of sets of criteria for admission, lengths of stay, and use of ancillary services.

Whether the aim is cost containment or expansion of primary care, the doctor is central to hospital survival plans. "Unless physicians, who control the accelerator and the brake of the medical system, change the speed at

A Course in Health-Care Finance

Rashi Fein came to Harvard in 1968 after five years as senior fellow in the Economics Studies Program of the Brookings Institution. Before that he was a member of the senior staff of President Kennedy's Council of Economic Advisors. He teaches "Issues in the Organizing and Financing of Health Care," in the Department of Social Medicine and Health Policy.

In the following interview, Fein talks about the relevance of his course to medical education, and about what he has learned of student concerns.

LWD: Let's start with reasons for a course about the issues in financing of health care. Why should medical students take it?

RF: First, there is the traditional reason: students are going to be in practice for 30 or 40 years after they leave here; the world will change; they ought to understand that world. Also, like it or not, society turns to physicians not only for clinical care, but also for the organization of medicine and its financing.

I think it's very sad if these professionals, who are turned to, and to some degree deferred to, by society, in fact are relatively ignorant about what it is that society is after.

There are other levels. A physician who doesn't really understand the difference between Medicare and Medicaid, and the way Blue Cross/Blue Shield and private insurance work, will not fully appreciate the concerns of his or her patient. Medical care is much more than the technology of cure.

The physician who attacks government and its regulations without understanding that we are a society of laws and regulations is going to feel more victimized than is necessary. A physician who doesn't understand what it once was like for the doctor to ration care on the basis of the family's income is going to be less appreciative of the degree to which some government programs are useful and beneficial for him or her, not just for patients.

I can look out the window here at the Huntington Green Line. The conductor on the Green Line is not an individual who, I believe, must be cognizant of U.S. transportation policy. But if doctors, Harvard doctors, want to think of themselves as professionals who can determine policy, and not just as technicians, then they have a responsibility to care about, and that means to *know* something about, American health-care policy.

I think it's fair to say that Harvard at this point does not require these bright students, some of whom are going to be the leaders of American medicine, to be exposed, let alone educated, to the fact that medicine is undergoing a lot of rapid change—change that will affect the relationship between doctors and patients.

continued on page 14

which they drive the engine, cost containment will probably not work," concluded a 1981 *JAMA* piece on the subject coauthored by Sankey Williams: "If the medical profession is to improve its own performance, if the fox is to guard the chicken coop, it is necessary to identify ways to change physician behavior."

How are those ways identified, and what kinds of changes can physicians expect? One place such questions are beginning to be answered is the Center for Cost-Effective Care, where work is under way to provide information about the efficiency of the hospital at an unprecedented level of detail.

The key to the data is the DRG, used here not as a payment tool, but as a way of studying costs. Use of hospital resources—ancillary, support, and clinical—is being broken down to levels as basic as laundry costs in the surgical ICU, and can be put back together to give a picture of how physicians use specific resources in the care of patients with particular problems.

Anecdotal evidence from a group of residents offered a small reward for cost-effectiveness suggested they had "negative feelings about the use of an incentive."

On the clinical side, the center is engaged in a pilot study on the Orthopedic Surgery Service, in collaboration with chief Clement Sledge—and is now starting a study of the Cardiology Service.

Center staff JoAnna Van Gerpen and Emme Deland, both M.B.A.s, work closely with physicians to redefine relevant diagnostic categories. "The physician," points out McNeil, "must believe in the DRG data for it to influence his or her behavior."

One of the cardiologists now working with Van Gerpen and Deland is fellow Tom Lee. Faced, for example, with a page of dense federal DRG listings of "cardiac arrhythmia and conduction disorders age <=70 and/or cardiac cath," they ask: How can we make use of the data this description provides?—and then perform DRG surgery, lumping and splitting descriptions.

If a chief wants to ask: How do the physicians on my service compare to one another in their drug treatment of cardiac arrhythmia?, he or she does not want information on all the rhythm problems covered by the federal description. So the CCC staff breaks the category into two parts: arrhythmias treated with drugs, and those controlled with pacemakers—or fast and slow rhythms. They further note that cardiac cath is a procedure, not a diagnosis, and that the age of the patient may not be relevant to the kinds of questions the CCC wants to supply answers to.

In a matter of months, Lee and

continued from page 13

LWD: Do you think the increased interest in your course—the move from one to three credits in the spring semester—corresponds to what's actually happening out there in the world?

RF: I think the students in some sense are reflecting.... Look, they're confused. They know there are a lot of changes. They don't know what 372 is, but everywhere they go they hear about 372 or about DRGs. They don't know about the new ways of paying hospitals, but they know there's a lot being said in the hospital that seems to be different. They are being lectured at about benefit-risk ratios, about efficacy, about lab tests.

They are scared about the prediction of a physician surplus. They are heavily in debt, and are reading that their lives are going to be tougher perhaps than they thought. They are curious about what Mr. Reagan is up to. I think their desire for a longer, richer course reflects the fact that they're not growing up in a vacuum. There's something happening out there. They'd like to know more.

LWD: What concerns do the students bring to the course?

RF: I think it's fair to say that they by and large know very little. They don't know how the American health-care system and its financing has developed in the last 50 years, and that it has had some organic, natural evolution. They're interested in some nuts and bolts, in some understanding of the broad dimensions of the subject, and in the current issues. They want to understand more of the language they read in their daily newspaper about health care.

LWD: Speaking of the language, you once wrote about the dangers of adopting words like "provider," "consumer," and "patient compliance." You wrote, "I want physicians to practice medicine, not to become schizophrenic about their proper role." How does that thinking fit into your role as a teacher of the issues of the economics of medicine?

RF: I guess it fits in the following way. I have a high regard for American medicine and physicians. They are the agent of the patient, and they have a responsibility to the patient. That's something I've become exquisitely more aware of since spending 15 years at HMS. At the same time, society is calling upon physicians to conserve resources, to become more efficient. I guess what I try to do in class is talk about the dimensions of that problem, which I don't think the individual physician can solve. That is, I think the physician has to understand what's going on in society, but still has that primary responsibility to the patient.

The course I teach is not likely to lead one of my students to say to me in five years, "Professor Fein, we can take care of your problem, but I know you would agree with me that these resources would be better utilized in taking care of the problems of infant mortality in the inner city."

other cardiologists helping with the data, like the orthopedic surgeons before them, will be among the first physicians to see their names on a list of costs incurred by physician, per patient, on a clinical service.

"No one wants to be watched," Lee comments, "as in *1984*. But in the future our test-ordering patterns will be scrutinized. Just as in the best medical research, we'll learn from the exceptions and extremes."

How will the data be used to influence physician behavior? The CCC sees the first step as providing information, with two aims. First, the data will compare physician performance in the care of similar cases to that of their peers. "If you notice that one person uses enormously more resources, something needs to be discussed," notes Komaroff. "Are some people overutilizing resources? Are others underutilizing them? There are no easy or obvious answers—and variability in practice patterns is a dramatic reality in medicine—but these are questions all of us must discuss."

To deal with the variability, Komaroff projects, one would first gather physicians together to examine the data, and hope discussion would follow. The CCC finds the information on its own has much more of an impact than it would have five years ago. "The medical staff now has an awareness that it's in our interest to make efficient use of the hospital's resources," Komaroff comments. "We don't want to lose our workshop."

The second aim is to provoke thought even without discussing variability in practice, by presenting people with evidence of how they've used resources over a period of time. "On the Orthopedic Surgery Service," McNeil gives as an example, "Clement Sledge has found that his department does a large number of portable X-rays that may not be necessary." The information on its own may provoke discussion which will change behavior.

Outside the hospital setting, the HMO and fee-for-service systems are the two poles of the incentive possibilities in caring for outpatients. In the HMO there is an explicit reward for *not* doing; fee-for-service gives an explicit reward *for* doing.

Can such direct financial incentives work in a hospital? In one recent study (*NEJM*, 4 December 1980) residents at BWH were watched to see what would influence them to reduce test ordering. One group was offered a direct financial reward. Another attended ongoing chart review sessions. The last was a control group. The only lasting effect occurred in the group that was educated. Anecdotal evidence from those offered a financial reward suggested they had "negative feelings about the use of an incentive."

At BIH, Jerry Avorn comments, "Our earlier research (*NEJM*, 16 June 1983), has shown that physicians do improve their decision making with education alone, if that education is provided effectively. In general, doctors want to deliver high-quality care without squandering resources, and will do so if they are shown how. That is our goal: to educate rather than coerce. We think it will work." □

I want my students to understand that resources are limited, and that society may be forced to make decisions about priorities.

The course is in part about the question: "Are there ways of financing health care so that if we cannot do everything for everybody, what we can do will be made available on a more equitable basis?"

I want the student to understand how economists think because they influence policy, but I most want the student to understand how policy is shaped. It is not my purpose to make mini-economists out of doctors. When you finish the course, you understand the role of the House Ways and Means Committee, and of the Senate Finance Committee, that sort of thing. How does policy get enacted? What are the policy issues today? To the degree that economists contribute to formulating those issues, how does that happen?

LWD: When I read your course description I imagined medical students being faced with a myriad of choices about the type of medicine they would later practice. And I imagined they would take your course hoping they could become armed with knowledge that would help them make those future decisions.

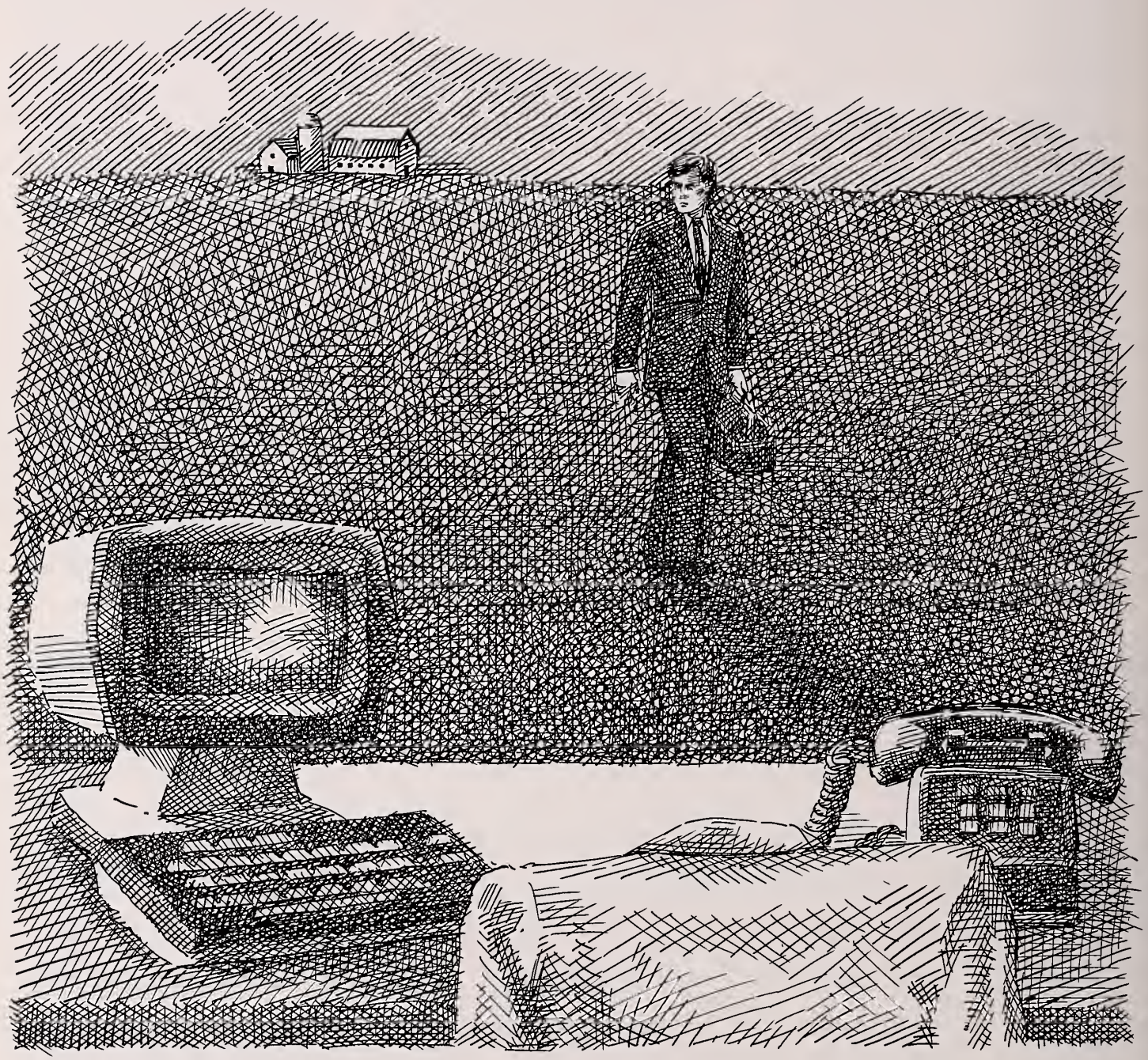
RF: I think that's true. It's not laid out in cookbook fashion, but I'd like to think they will understand more about how a prepaid group practice or other forms of HMO work, what the incentive structures are, become more acquainted with some of those patterns of organization. A high proportion of medical students spend a high proportion of time in hospital settings, and that represents only a part of medicine.

A good deal of the classroom discussion is about practice outside the hospital. A good deal of the course is also designed to remind students that medicine is more than the impact of medical care.

Take a patient whose physician says, "You're going to be all right. It's going to take a couple of weeks for this to clear up." Now, had the patient not consulted the doctor because health insurance didn't cover it, two weeks later the patient would have still been better. Some of the data would purport to tell us that it therefore doesn't make any difference whether or not the patient is reassured by the physician. I'm arguing that two weeks of a measure of peace is not to be discounted. We don't know how to measure it, but an awful lot of people go to doctors for reassurance, and they are happier as a result.

Anybody who forgets that part of medicine is ignoring perhaps one of its more important components. I would like to think that doctors and our students know that. I am impressed that an awful lot of economists don't seem to know it, or at least don't measure it, and therefore tend to ignore it.

I'm not sure that when students finish my course they're frightfully better equipped to make their own life decisions, but I would like to think they are better able to understand some of the issues that will face American medicine, and are likely to be better equipped to think their way through the implications of the various options that face society. □



Modern Times

The Business of Being a Doctor

by Sankey V. Williams

ILLUSTRATION BY KATHERINE MAHONEY

My father had a lot to say about doctors and money, probably because he struggled with the issue all his life. Starting in a one-room school in eastern Kentucky, he received his M.D. from the University of Louisville in 1936. Throughout his undergraduate years during the Depression, he attended school one semester, and then worked the next so he could continue. I lost count of how may semesters he spent at which college.

His stories about the work were entertaining. As far as I know, it was the only time in his life he was shot at. In one of the state's poorer counties, where nearly everyone qualified for public assistance, he was at one time the clerk responsible for certifying need. One applicant disagreed with my father's assessment and took direct action. Luckily, he was a poor shot. Another job involved floating down the state's rivers identifying marijuana for destruction. It is easy to understand why these job alternatives did not keep him long from his childhood dream of becoming a doctor.

One of my father's favorite stories was about his first day as an intern. During a no-nonsense orientation, the sister in charge announced that the salary was $25 a month. Although room and board were provided, this sum was all he would have for personal expenses, which, as it turned out, included courting the pretty nurse who became my mother. He laughed when asked if each month's wages should be paid in cash or placed in a savings bond.

Sankey Williams '70 is assistant professor of medicine, associate director of the Leonard Davis Institute of Health Economics, and Henry J. Kaiser Family Foundation Faculty Scholar in the Section of General Medicine at University of Pennsylvania. Cost containment has been one of his major interests for several years. He has investigated methods of influencing physician practice behavior; lately he has been evaluating the DRG reimbursement system.

The question has become not whether to provide care for nothing, but whether to provide it for those whose third party will pay less than we charge.

The economics of general practice in a small Kentucky town were clear, inescapable, and difficult. The rewards were not financial. My father loved his practice, and his patients were good to him in return. They treated him as an important and respected friend. Some of the children he delivered were named after him. There were other, more tangible, rewards. I remember the fresh tomatoes and corn brought to our back door at the end of the summer, and the baked goods and the occasional country ham during the holidays.

It was only later that I connected these gifts with the two filing cabinets in my father's office. Both contained large index cards on which he wrote a line or two along with the charge after each office visit. The filing cabinet of unpaid bills was almost full. The other was not. He would not turn away those who could not pay, and these were the people who brought their summer produce to our back door.

I never did figure out how much this arrangement bothered him. He took great pride in contributing his services to the community. But I remember mornings when he would return to join us for breakfast, exhausted after another late-night home delivery, with a full day's work in front of him. His pajamas would be sticking out from under his suit—there had been no time to dress properly when the call came. In telling the story, he had to mention that he had delivered six children to this family without payment, and his excitement was heightened by frustration and perhaps anger.

I also remember family talk about the county's other doctors. My father held them to a high standard, and often they did not measure up. This one did not pause to listen. That one meant well but had become outdated. Another had trouble understanding his patients because of a difference in cultural backgrounds. There was more sadness than disapproval in my father's voice—until he talked about their high fees. Worst were the outside doctors who sought his advice about opening a practice in this town that desperately needed more doctors; all they seemed interested in was the money.

Many may find all this hard to believe, but there was a time, not so far removed, when most doctors lived by the economic rules that determined my father's life. Some still do. For most of us, however, the options have changed. I am a general internist in a multispecialty group. Instead of index cards, we have a computer-based system that prints a "superbill" for third-party payers. As late as 1960, when my father's practice was most active, if health-care bills were paid, over half were paid directly by the patients themselves. In 1982, patients paid only 28 percent directly. (Government programs paid 47 percent, private insurance 29 percent.)

For my colleagues the question is not whether to provide care for those who will pay nothing, but whether to provide care for those whose third party will pay less than we charge. Our computer file of unpaid bills is much smaller than my father's file cabinet of never-to-be-paid bills, but that's not all that has changed. Our patients respect our skills and believe we are honest—but no one names children after us, and few bring us the fruit of their labor. I wonder how much this has to do with turning un-

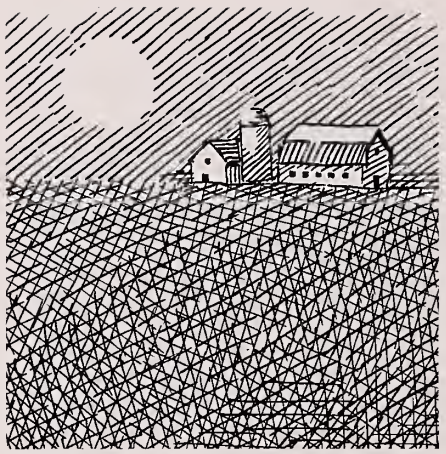
paid bills over to a collection agency, no matter how ethical, and how much is related to the monthly charts I receive from our business manager comparing my per-patient earnings with the group's mean.

My father was paid cash by the patient as the office visit was concluded, which forced both of them to consider the immediate value of the services rendered. I am paid a salary each month, plus an incentive based on "productivity."

The exchange of dollars is kept distant from me by my business office, and often from the patient by his or her third party. My patients and I use a modification of the fee-for-service system that shields both patient and doctor from the troubling business of deciding what medical care is worth, at least when the decision is made about how much care is needed. There is some value here, because the patient may not be prepared to make such an important decision when he or she is acutely ill, or is afraid that he or she might be.

How much such shielding has contributed to the increased cost of medical care is unknown, but some believe it is the principal cause. Certainly there are other causes. Every year I practice, there is more I can do that actually changes the outcome for more patients—new drugs, new diagnostic tests, new opportunities for referral to more specialized consultants, for still more unbelievable procedures. (It is sobering that my father's work was so valuable to his patients without these marvels of technology and science.) Although the benefit is worth the increased cost in these cases, the cost must be paid. Also, the number of elderly patients, and especially of "very elderly" patients, is growing, inevitably bringing greater cost because of their greater needs.

No matter how long the list of justifiable reasons for increased cost, however, it is true that some, perhaps most, costs could be reduced if greater effort were given to finding equally effective but less costly alternatives. How could it be otherwise under this payment system?



My practice operates under much the same fee-for-service system that my father's did. The more I do, especially the more procedures I perform, the more I am paid. When I am uncertain how much to do (and uncertainty seems to shadow every important decision), it is all too easy to do too much. My patient appreciates the effort; his or her third party does not complain about the price, as my patient might if he or she had to pay directly; and I can sleep better knowing that an extremely rare disorder has been eliminated from consideration in my diagnosis. To complete matters, my business manager calls to congratulate me for having raised my per-patient earnings above the mean.

When Steve Schroeder '64, pioneer investigator in this field, examined this issue several years ago in the journal *Medical Care*, he concluded that doctors could triple their office income by spending less time talking with patients and thinking about their problems, and more time performing diagnostic tests and other procedures.

It is for this reason that those who are most concerned about cost are supporting alternative payment systems for doctors. Some of the alternatives have been around so long that they are generally accepted, such as the straight salary system. Others, like the health maintenance organization (HMO), and the independent practice association (IPA), have become so common in recent years that they no longer seem strange.

In HMOs and IPAs, the group's income depends on the difference between the patients' predetermined capitation fee and the cost of care, which puts the HMO or IPA at risk for real losses if too much is done at too high a cost. Years of study have shown that HMOs and IPAs do have lower costs, by as much as 10 to 40 percent, and that there are few differences in the type of care that is provided, except that patients are admitted to the hospital less often.

What remains unclear, however, is why this reduction occurs. It may result from the clinical styles of the doctors who choose this type of practice, from the better health of the people who join, from the economies of scale and more intensive peer review that are inherent to these large organizations, or from the improved management provided by the professional administrators. It is unclear what role the doctor's financial stake plays, in part because there are so many different payment arrangements, ranging from straight salary to direct risk sharing.

Many observers believe that HMOs and IPAs, regardless of their effectiveness, will not solve the problem of rising costs, because not everyone likes being restricted to a single HMO's doctors and sites. Optimistic estimates are that only 20 percent of the population will join, even when HMOs and IPAs become much more widespread than they are now.

Newer arrangements (with obligatory three-letter acronyms) have therefore been developed. They include the Diagnosis Related Group (DRG) system and the preferred provider organization (PPO). If my group were to become a PPO, it would contract with a third-party payer to provide services for reduced fees. In return, the third-party payer would waive some of its deductible and copayment

ILLUSTRATION BY KATHERINE MAHONEY

requirements when subscribers came to us, which would encourage them to use us instead of someone else.

Theoretically, everyone would benefit. The total medical bill would be lower because of our reduced fees; my group would more than make up for the lower fees by seeing more patients; subscribers would have freedom of choice, yet many would pay less out of pocket; and the third party would attract more subscribers. Although other doctors would lose their patients to us, they could start their own PPO—and increased competition is the ultimate goal anyway.

California and some other states have begun experimenting with PPOs, but too little is known yet about whether they control costs or cause new problems. I wonder about the preservation of the fee-for-service incentive. Once every doctor has become a member of a PPO, everyone's fees will be lower. Still, all of us will be paid more when we do more to each patient, and we may be tempted to do too much, as greater competition will prevent us from raising prices to maintain our incomes.

The DRG system may offer a viable alternative. Based on the perceived success of a statewide demonstration project in New Jersey, the Health Care Financing Administration has begun paying acute-care general hospitals for Medicare patients under the DRG system in 46 states. No matter how long the patient stays, or how much the care costs, the hospital is paid a standard amount that depends on the patient's case type.

Case types are defined using several characteristics, including the patient's diagnoses, age, and surgical procedures. Each case type forms a separate "diagnosis related group," or DRG. Because payment does not depend on cost, the hospital loses money when costs are greater than the standard amount, and profits when they are less.

The DRG system puts powerful incentives in place: the hospital's very survival may depend on its ability to control costs. To control the unit cost of each service, the hospital must bargain more effectively with employees, and it must seek less expensive sources of supplies and equipment. To respond most effectively, the hospital also must find some way to reduce the number, and change the mix, of services provided to its patients—without changing the outcomes. Because the hospital's doctors order all these services, the hospital must, therefore, find some way to influence clinical practice.

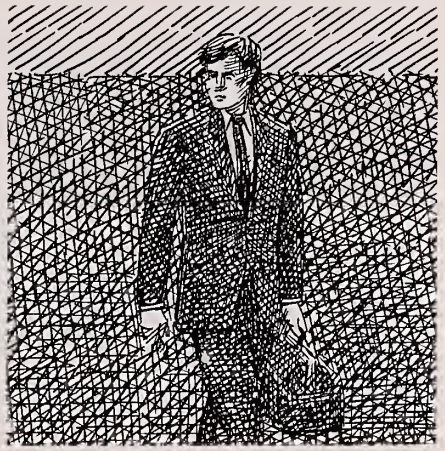


Illustration by Katherine Mahoney

Although this hospital focus on clinicians is reason enough for doctors to be interested in the DRG concept, there is more. If successful for the payment of hospitals, the DRG system likely will be extended to the payment of doctors. Most observers predict that the system will be successful, although no convincing evidence is yet available. This perception is so strong that some Blue Cross organizations already have adopted the DRG system for their patients' hospital payments. To prepare for the possibility of a prospective payment system for doctors, Congress has instructed the Health Care Financing Administration to design a system by October 1985.

It is unclear how such a system might work. In the mid-1970s Pennsylvania Blue Shield conducted a pilot study that could serve as an example. Ninety-one doctors in 10 hospitals agreed to receive a single, lump-sum payment for their services when patients with one of 23 selected diagnoses were admitted to the hospital—regardless of how long the patients stayed or how many services were provided.

The lump-sum payment was calculated as the average amount paid for physician services for that diagnosis in the previous year, adjusted for inflation. Using historical and concurrent controls, the patients in the study group had lengths of stay three percent shorter, and costs close to one percent lower, considering hospital and physician costs together. While small, these differences were statistically significant.

I can only speculate about what my father would say regarding all this. Probably he would wonder why we are spending so much energy worrying about getting paid when so much real doctoring remains to be done. This was one response he had to the turmoil that preceded the introduction of Medicare and Medicaid in 1966, although conservative politics influenced his position (which I disagreed with then because I mistakenly thought that I knew enough to do so).

In my father's time and place, the question of payment was no less real and no less important. There was, however, a clearer understanding about what a doctor should strive for when providing care and asking for payment.

Today we know better how to run the business of being a doctor, or we band together in groups and hire someone to do it for us. We also know how to make more accurate diagnoses, cure more people, and relieve more physical suffering. We cannot, however, improve on the respect and understanding that once passed between some country doctors and their patients. Our future would be more satisfying if we tried harder to recapture those relationships as we design the grand schemes that might lead to cost control. □

The Prospect of Prospective Pricing

Thoughts from the First DRG State

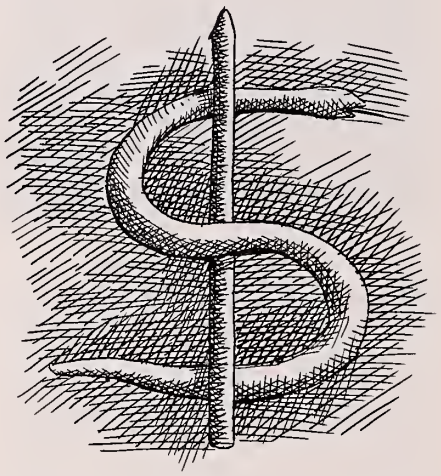
by James S. Todd

For the past three years, New Jersey has been a testing ground for a radically new payment system for hospital patients. This year a similar system was mandated for Medicare patients in 46 other states. Below, New Jersey surgeon James Todd '57, also a councillor of the Harvard Medical Association and a trustee of the American Medical Association, shares his thoughts on these developments.

The new prospective pricing system (DRG reimbursement) enacted into law in April 1983 for Medicare hospital payments at first look would appear to place hospitals and physicians in adversary positions.

Traditional reimbursement mechanisms have long rewarded health-care facilities for expanding, for offering more complex services, and for providing care to ever greater numbers of patients. To some degree the medical profession, by responding to open-ended financing, has contributed to such growth. Seventy percent of health-care costs are generated by what we as physicians decide our patients need, and the great majority of these costs are generated by what we do in hospitals.

The current incentives for physicians to do more to and for patients are in conflict with the new financial incentives for hospitals. Under the DRG system, hospitals will receive a fixed reimbursement, determined in advance, for 468 diagnostic related groupings of disease. There are modifications by age and invasive procedures, and parameters to compensate for exceptions, but fundamentally hospitals will receive $X for a case of appendicitis, $Y for a myocardial infarction, and so on. If the hospital can provide the care more cheaply,



it keeps the profit. If the cost exceeds the payment, the hospital must assume the loss. The system is going to force hospitals and physicians to look at what they're doing and how much they are doing it.

While DRGS initially apply only to Medicare patients, there is every reason to expect extension to all payers, and Congress is mandated to decide by 1985 whether physician reimbursement should also be determined under DRG principles.

After three years' experience with a pilot DRG program in New Jersey, I cannot tell you whether it is a good or a bad system, or whether it has saved any money. But I can tell you that it has profoundly affected the manner in which hospitals are being managed. Cost accounting has assumed a new importance, staffing patterns are being revised, medical staffs are more involved in administration activities, and the record room has assumed enormous importance.

The New Jersey system is similar to that of the federal program, but covers all hospital payers, not just Medicare, thus eliminating the potential for shifting costs to others. Preliminary indications are that the average length of stay for patients has been reduced by an estimated 16 days, and that the escalation of costs has slowed. It looks like physicians are also responding, by planning ahead more effectively, using outpatient services more, and striving to discharge patients as soon as possible. Despite isolated anecdotes, it is far too early to make judgments about potential deterioration in quality of care. Nor have any malpractice consequences been seen.

The prospective pricing system does impose new burdens on the hospital, and the expense of its implementation may overshadow potential savings. It requires automated data processing, a sophisticated financial department, and an exceptionally efficient and dedicated record department, since payment depends upon the accurate and speedy completion of records to determine the proper DRG classification. Small errors in coding can result in the loss of many dollars.

For the physician, the system means increased scrutiny of cost as well as quality. In the future there will certainly be increased administrative pressure to stay within DRG tolerances, yet maintain hospital census. Budgets will be tighter and marginal services eliminated, or perhaps regionalized, with the attendant danger that some needed services will no longer be locally available. Education and research that are expensive and provide little tangible return may be reduced or eliminated. Conceivable consequences of the system might include the sudden unavailability of accommodations for patients who heavily consume resources, or ostra-

ILLUSTRATION BY KATHERINE MAHONEY

cism of physicians based on their cost to the hospital.

In its most naked form, the DRG system is a measure of resource consumption. It was initially developed in 1970 by a group of Yale health researchers, whose aim was to develop appropriate utilization standards, presumably resulting in better quality care. They devised a system for defining groups of patients with diagnoses likely to require similar quality of care and lengths of stay. Others who looked at this work, mostly regulators, believed the system could be used as a basis for reimbursement, and DRG prospective pricing came into existence.

For the first time, data are available to show physicians how they individually contribute to a hospital's cost and efficiency on a per-case basis. It would be difficult to argue with the usefulness of this information, but its application as a reimbursement mechanism could result in such potential adverse manipulations of the system as unconscionable cuts in payments, or in undue and potentially damaging influences on the ways physicians practice—or on their reputations. Worse, payments could be reduced to a level at which a hospital may not be able to continue a needed service, or to obtain and use new technology, thus depriving patients of needed care.

Such concerns transcend issues of prospective payment. If physicians are truly to fulfill their professional responsibilities, they must increasingly look beyond their personal desires and individual practices. No longer is it sufficient to practice high-quality medicine without paying attention to the profession at large and the society in which we live.

In large measure we are now victims of our own success. By virtue of unprecedented growth in science, technology, and patient care, albeit aided and abetted by public subsidy and population shifts, we are doing more things for more people and they are the better for it.

For the physician, the system means increased scrutiny of cost as well as quality. There will be increased pressure to stay within DRG tolerances, yet maintain hospital census.

This tremendous expansion of capabilities, however, has brought with it many unanticipated problems, the most acute of which is the escalating cost of medical care—accompanied by society's withdrawal of its open-ended commitment to financing it. There is no need to recount the statistics, which are well known to all of us. Without question, the government, private health insurers, industry, and labor are determined to do something about these costs. What we must fear most is a bottom-line mentality that will sacrifice quality and accessibility for the sake of economy.

The most likely negative result of prospective payment will be the merchandising of health care for purely economic reasons. It may well be that under this system the cost per case will decline, and the average length of stay shorten—but to what advantage, if, by increasing demand through merchandising, the number of cases treated increases, and in the aggregate health-care costs continue to rise?

While such opportunities exist for abuse, the system does have the potential to increase quality accountability as well as cost accountability. As they become more selective in choosing tests and procedures, physicians might well practice better medicine. By the same token, it is our responsibility to be sure that prospective payment does not become a tool to strangle our ability to provide needed care.

These new Medicare regulations virtually demand that physicians and hospital administrators work together to restrain length of stay and use of ancillary services and procedures. They are encouraged to do so not by changes in incentives to physicians, although that may be the next step, but by penalizing the hospital if the physician fails to cooperate.

Administration and hospital boards will struggle to reshape their institutions, for if they don't, some will not survive. The physician must realize his or her stake in all of this, as physician understanding, cooperation, and support are critical. Hospitals can provide a number of potential advantages in the tightening market of health care, and an efficiently run hospital with a competitive, well-organized medical staff is essential to successfully coping with DRG reimbursement.

Accountability is now the name of the game. Enlightened self-interest requires physicians to participate meaningfully in any program—scientific, social, or economic—calculated to maintain and improve health care. It is the physician's absolute responsibility to be steadfast in refusing to compromise quality—properly defined.

If health maintenance organizations (HMOs) have proved nothing else, they have demonstrated that costs can be cut by reducing hospitalization, without sacrificing quality. We cannot, and probably should not, do everything scientifically possible for everybody, everywhere, all the time.

The standards and freedoms we now enjoy are the result of the endeavors of organized medicine and earlier dedicated physicians. It is clearly our responsibility to see that those who come after us, physicians and patients alike, will continue to enjoy the successes of modern medicine. It is incumbent that we all look to our own practices, whatever mode they may be, assuring that they are safe, effective, economical, and in the best interest of the patient. Society should expect and receive no less. □

On the Proposed Sale of McLean Hospital

This past summer and fall, Massachusetts General Hospital gave serious consideration to an unusual partial solution to its financial needs: Hospital Corporation of America, a for-profit entity, had proposed to purchase McLean Hospital from MGH. One of the conditions of the HCA proposal was that Harvard Medical School continue its affiliation with McLean.

In a letter to the faculty of medicine in September, Dean Tosteson wrote that he had been approached with this information in June by Francis H. Burr, chairman of the board for MGH and McLean. The dean agreed to consider the affiliation after being assured that two basic conditions would be met: "that the research and education aspects of the program at McLean be under the control of HMS, and that no Harvard faculty be employed by a for-profit corporation." He then appointed a faculty committee, which produced the report printed below. In a world where physicians increasingly wrestle with the relationship between money and medicine, this report serves as documentation of the struggle.

So long as the relationship of McLean, HCA, and the trustees of MGH was under advisement by a special committee of the medical school, the Bulletin *purposely avoided adding its voice to the considerable clamor.*

Now that the immediate issue has been resolved and the report of the advisory committee has been circulated to the faculty, the alumni should have first-hand knowledge of the reasons for decisions taken. Both the dean and Francis Burr look kindly on the publication of the report and their correspondence in this regard. Both also remind the editor that although the immediate question is answered, long-range solutions have not been reached. These are being considered by a committee of the trustees of MGH and McLean, with representation from HMS and the staffs of both institutions.

The report and the correspondence speak for themselves, but must be viewed in light of changes that are occurring in the complex world of medicine in answer to the question of how to finance patient care, research, and teaching. In our last issue we spoke of the relationship between the university and corporate industry illustrated by the newly established Department of Genetics. The McLean affair has touched on the equally important issue of medical care as part of corporate industry. The intensity of the immediate response left no doubt as to the importance of the subject. Feelings ran high.

Hear again the voice of Edward D. Churchill in his presidential address before the American Surgical Society in 1947 (I have taken the liberty of substituting the word "medicine" for "surgery"):

"In times of change there is need for wisdom both in the external social order and within the profession. Spokesmen who loudly proclaim measures based on self interest will not be tolerated. A hold-fast in Science is essential, but this represents only a part of the strength of medicine. By maintaining the ancient bond with humanity itself through Charity—the desire to relieve suffering for its own sake—medicine need not fear change if civilization itself survives."

—J. Gordon Scannell

November 1, 1983

To Members of the Faculty of Medicine:

In my letter of September 19, I informed you of the offer that Hospital Corporation of America (HCA) has made to purchase McLean Hospital from Massachusetts General Hospital Corporation (MGHC). Mr. Francis Burr, chairman of the Board of Trustees of the MGHC, asked me whether Harvard Medical School (HMS) would continue its affiliation with McLean if it were owned by HCA under the terms of the proposal. He made clear that neither the MGHC board nor HCA would be interested in the arrangement in the absence of an affiliation with HMS. In August, I appointed an ad hoc committee of senior faculty members to advise me on this matter.

Copies of the final report of the committee and of a letter containing my reply to Mr. Burr are enclosed. On the basis of the conclusions of the report and opinions that have come to me from many members of the faculty, I have told Mr. Burr that I cannot make a commitment that HMS would continue an affiliation with McLean were it owned and operated by HCA under the conditions of the proposal.

There are two principal reasons for my decision. First, as dean, I do not think we should enter into this agreement when it is opposed on grounds of deeply felt values by a majority of our faculty members who are working at McLean. Second, I concur with the committee that the hospital would function poorly under an arrangement that is not acceptable to most of its professional staff. Such a result would not be in the best interests of the participating institutions or of the society they serve.

For several reasons, I reach this conclusion with some reluctance. First, I recognize the seriousness of the long-term capital requirements of the two hospitals (McLean and MGH) owned by the MGHC and their importance for many academic programs of HMS. Second, I admire the ingenuity of Mr. Burr and members of the Board of Trustees of the MGHC in searching for new ways to meet these requirements. Third, I have long believed that stronger cooperative agreements between private research universities and private or investor-owned corporations would benefit both sectors and society at large. Fourth, I am impressed with the concern shown by HCA for the necessity to preserve and strengthen the integrity, independence, and quality of the professional services and the academic programs at McLean.

Despite these considerations, I think it would be unwise to proceed with the proposed sale, not only because of the opposition of most of the members of the faculty at McLean, but out of respect for the origins of that opposition. The McLean and Massachusetts General hospitals were born siblings and are the oldest children in the HMS family. Both have flourished as charitable institutions serving the sick and suffering of Boston and environs for more than one and a half centuries. Understandably, the proposal arouses not only separation anxiety but also legitimate concern about the long-term consequences of a fundamental change in organization. Let the record show that the members of the Faculty of Medicine at Harvard really care about their institutions.

I am grateful to many individuals who have contributed to the thoughtful exploration of this important matter.

First and foremost is Mr. Burr, who has devoted so many years of thoughtful and dedicated service to Harvard and MGH, and who placed such weight on the opinion of the school about a proposal made to the MGHC. Others are Joseph Martin and the other members of the ad hoc committee who gave many hours and much effort to considering and advising me about the proposal. Not least are the many members of the faculty, students, alumni, and friends of the school who contributed to the study in writing or verbally at meetings of the ad hoc committee, the Faculty Council, or the Conference of Department Chairmen. All of you have made this an exercise in social responsibility worthy of Harvard Medical School.

Daniel C. Tosteson
Dean

November 1, 1983

Dear Mr. Burr:

The Faculty Advisory Committee on McLean Hospital, which was created to review the proposal from Hospital Corporation of America to acquire McLean Hospital, has submitted its report. The committee recommends that the proposal not be accepted.

The report concludes that the proposal from HCA offers some potential benefits, and that many of the risks it poses are or could be minimized through provisions in the contract. The committee's reasons for recommending rejection do not relate to specific terms of the proposal or to the capabilities of HCA. Rather, the committee urges that the proposal be dropped because it believes that opposition in the faculty is so strong and based upon such deeply held values that it would be impossible for McLean to function effectively if it were sold to HCA at this time.

In light of the report, I cannot assure you that HMS would continue its affiliation with McLean if it were sold to HCA under the terms in the current proposal. As dean, I do not think we should enter this agreement when it is opposed by a majority of the members of the faculty most involved and affected. Furthermore, I concur with the committee's judgment that McLean would function poorly under an arrangement that a majority of its professional staff cannot accept. In my opinion, such a result would not be in the best interests of any of the participating institutions or of society at large.

On behalf of the faculty, permit me to thank you and your fellow trustees for your vigorous and creative efforts to meet the serious capital requirements of the McLean and Massachusetts General hospitals, both of which house essential academic programs of Harvard Medical School. I agree with you that we must continue to explore all avenues toward financial stability of our institutions. Your long and distinguished service as a fellow of Harvard College and now as chairman of the board of the MGHC makes you unusually well qualified to understand and to devise strategies to resolve problems facing academic medical centers. I look forward to working with you and the other trustees of MGH in seeking the resources needed to sustain the quality of our programs of patient care, research, and education. I am confident that we can find solutions that will be supported by most of the members of the faculty.

I will be grateful for your response to this matter.

Daniel C. Tosteson
Dean

November 1, 1983

Dear Dean Tosteson:

I hasten to respond to your letter enclosing the report of the Faculty Advisory Committee on McLean Hospital.

Although I am disappointed in the committee's conclusion, I am pleased that the committee recognized the many excellent features of the proposal. Indeed, the report clearly recognizes that the agreement we were negotiating offered a remarkable solution to the problems of McLean and the patients. However, I understand the concern that the strength of the opposition on the part of a large number of the professional staff at McLean would make the effective implementation of the proposal extremely difficult.

I would like to inform you that, as I have frequently said during the time that this matter was in discussion, the conclusion of the committee means that we shall not proceed further with the proposal. The Board of Trustees has authorized me to appoint a committee to consider various alternatives with respect to McLean and its financial needs. It has further authorized me to state that we do not consider that maintenance of the status quo is acceptable. We will begin immediately to seek alternative solutions in an attempt to ensure McLean's long-term survival as one of the nation's finest psychiatric institutions.

Francis H. Burr

Final Report of the Faculty Advisory Committee

November 1, 1983

Introduction

The Faculty Advisory Committee on McLean Hospital (the committee) was formed on August 2, 1983, the same day the first public announcement was made of the offer from Hospital Corporation of America to purchase McLean Hospital. The committee's task was to advise Dean Tosteson on the appropriateness and desirability of the proposal and to identify the conditions under which Harvard Medical School might participate. It has been the committee's understanding throughout its deliberations that, from the perspective of the trustees of Massachusetts General Hospital Corporation as well as that of Hospital Corporation of America, the sale of McLean would be attractive only if its affiliation with HMS could be continued.

The Committee membership:

Chairman:
Joseph B. Martin, Bullard Professor and chairman of neurology, MGH

W. Gerald Austen '55, Edward D. Churchill Professor and chairman of surgery, MGH

Shervert H. Frazier, professor and psychiatrist-in-chief, McLean Hospital

Seymour S. Kety, professor of neuroscience emeritus, McLean Hospital

Philip Leder '60, John Emory Andrus Professor and chairman of genetics, HMS

John E. Mack '55, professor of psychiatry and chairman of the Executive Committee, Cambridge Hospital

John T. Potts, Jackson Professor of Clinical Medicine and chairman of medicine, MGH

Miles F. Shore '54, Bullard Professor of Psychiatry and superintendent, Massachusetts Mental Health Center

William Silen, Johnson and Johnson Professor and chairman of surgery, Beth Israel Hospital

In addition to its membership, the committee received staff support from David M. Bray, dean for management and administration, HMS; Ann L. Schwind, director of planning, HMS; Daniel Steiner, vice president and general counsel, Harvard University.

The charge from Dean Tosteson to the committee included 10 questions aimed at the potential effects of the proposed sale of McLean on all three aspects of the academic mission: patient care, education, and research.

The major provisions of the HCA proposal can be summarized as follows:

1. McLean Hospital would be sold by the trustees of the MGHC to HCA for a price to be negotiated, but probably in the range of $40-60 million.

2. HCA would run McLean as a for-profit subsidiary. Two other new corporate entities would be created as well: a not-for-profit professional association and a not-for-profit research division (see points 8 and 9).

3. HCA would fund the planned $35 million renovation project at McLean and would create endowments to support five professorships at McLean in perpetuity.

4. Free patient care would continue to be provided at the same proportion of gross revenue.

5. Amounts currently contributed from hospital operations for education and research would be continued at inflation-adjusted levels.

6. A governing committee for McLean would be established with a majority of its members selected by HMS and the trustees of the MGHC. This committee would have sufficient authority to oversee the quality of patient care, education, and research carried out at McLean.

7. The traditional academic freedom enjoyed by members of the staff at McLean would be protected, and appointments and promotion of professional staff would continue to be governed by existing standards and procedures; i.e., those of HMS.

8. A not-for-profit professional staff association similar to those existing in other teaching hospitals would be established. It would be made up of the HMS faculty members who provide patient care at McLean. Harvard faculty would be employed by the staff association, which would contract with McLean to provide professional services.

9. Corporate responsibility for research carried out by Harvard faculty at McLean would be transferred to HMS. Responsibility for the scope and quality of research would continue to reside with the chairman of the Department of Psychiatry at McLean.

10. HCA would agree, if in the future it wishes to sell McLean or to cease operating it in accordance with agreed procedures, that the MGHC would have a right to repurchase at a favorable price.

The committee views this proposal as a serious, imaginative, and good faith effort by the trustees of the MGHC to find the capital needed to modernize its two hospitals. The committee recognizes that the economic climate now and in the foreseeable future demands some kind of innovation. Indeed, the committee sees many potential benefits, some specified in further detail later in this report, that would accrue to the participating institutions and to society if the proposal were adopted. The committee also notes that many of the risks, raised by Dean Tosteson in his charge and by various witnesses, could be effectively reduced by safeguards included in the contract between HCA and the MGHC. For example, professional services, research, and education would remain under the control of the faculty either through a not-for-profit practice association or through HMS.

Despite this basically favorable review, the committee recommends that the proposal be rejected. Reactions from members of the faculty, even from those at the McLean and General hospitals who would be the primary beneficiaries of the proposal, have been overwhelmingly negative. In the judgment of the committee, it would be destructive for HMS to enter into an agreement that is strongly opposed by the faculty members who are most involved. Moreover, the committee believes that proceeding with the proposal in the face of such opposition would not be in the best interests of any of the parties because it would be difficult or impossible for McLean to function effectively under such circumstances.

The origins of the strong negative reaction that leads the committee to recommend rejection of the proposal are complex. In the judgment of the committee, most of the negative reactions are not based on an assessment of the specifics of the proposal and/or of the previous performance of HCA. Rather, the reactions seem to flow from a set of values strongly held by many members of the faculty. This value system finds a close relationship between Harvard and a for-profit health-care provider to be wrong because it would tend to sustain penetration of the health-care system by investor-owned companies. These ethics hold that the operation of hospitals, particularly teaching hospitals, should not be influenced by the motivation for profit. The committee concludes that, because of the importance of the value question and the intense concerns of the faculty, it would be unwise to consider this specific proposal further at this time.

The committee has devoted considerable effort over the last three months to examining the proposal. Even though its final recommendation is to reject the proposal in its present form, the committee thought it would be valuable to include in its report a detailed discussion of the benefits and risks it saw in the proposed agreement. The committee's hope is that its analysis might be useful for other groups considering similar proposals, and for the study of for-profit health-care delivery in general. A number of alternative arrangements for affiliation with the for-profit sector were discussed; such options might be appropriate for future consideration.

Much of the remainder of this report is devoted to this discussion of benefits and risks. The report does not suggest alternative solutions to the financial needs confronting the trustees of the MGHC, since that is beyond the scope of the committee's charge. Nonetheless, the committee believes that these financial needs are real, and that the faculty has an obligation to collaborate with the trustees to reduce the gap between needs and resources.

Medical services... have not been of sufficient financial magnitude, in comparison with the great bulk of commodities, to attract more than passing attention from economists. Also, medical practitioners have rightly been preoccupied with the more technical aspects of medicine. As a result, the economic phases of medical service have been largely nobody's business.

—"Medical Economics," Douglass V. Brown, *HMAB* (January 1935)

Overview of Process

When Dean Tosteson formed the committee, he asked it to complete its work in two to three months. This was a short time frame given the complexity of the issues raised

by the proposal, but there were several reasons for a prompt evaluation. First, the proposal created a significant amount of uncertainty and tension at McLean, which damaged morale. A prompt recommendation by the committee would help end some of that uncertainty. Second, the trustees of the MGHC deserved a prompt response so they could either proceed to negotiate with HCA or identify other solutions to the financial needs of the two hospitals.

The committee met on 12 occasions over its three-month life. It collected data and opinions from many different sources, including interviews with the following individuals:

Francis H. Burr, chairman of the Board of Trustees, MGH

Francis deMarneffe, general director, McLean Hospital

Donald MacNaughton, chairman of the board, HCA

Thomas F. Frist Jr., president and chief executive officer, HCA

Charles N. Martin Jr., senior vice president for acquisitions and development, HCA

Paul Starr, assistant professor of sociology, Harvard University

Arnold S. Relman, editor, New England Journal of Medicine

Thomas P. Hackett, Eben S. Draper Professor and chairman of psychiatry, MGH

Alfred Pope '41, professor of neuropathology emeritus, and chairman of the Research Committee, McLean Hospital

Edward R. Shapiro '68, associate clinical professor of psychiatry and representative of the Joint Appointees, McLean Hospital

Golda Edinburg, director of social work, McLean Hospital

Jeffrey Victoroff, resident in psychiatry, McLean Hospital

The committee also invited three other witnesses who were unable to accept its invitation: Governor of Massachusetts Michael Dukakis; Joe B. Wyatt, chancellor, Vanderbilt University; and H. Keith Brodie, James B. Duke Professor of Psychiatry and Law and chancellor, Duke University, and former president, American Psychiatric Association.

The committee's interest in interviewing Chancellor Wyatt stemmed from the recent agreement between Vanderbilt University and HCA to enter into a joint venture for the construction and operation of a child and adolescent psychiatric hospital. The committee received copies of the contracts relevant to this partnership agreement from HCA. Chancellor Wyatt was also interviewed over the telephone for his impressions of HCA.

The committee received letters from a large number of individual faculty members and other interested parties. The proposed sale of McLean was discussed in October by the HMS Faculty Council and the Conference of Department Heads, and input from these groups was made available to the committee.

The committee educated itself about HCA and the for-profit hospital sector in general. It reviewed numerous studies and journal articles on these topics. It also conducted a telephone survey of medical staff and administrative leaders at 17 HCA hospitals.

This survey was done in order to get a flavor of the performance of HCA from the perspective of physicians practicing in its hospitals. The survey covered a broad array of issues of interest to the committee, including quality of patient care, patient costs, and the authority granted to the local hospital governing boards. The hospitals included in the survey were selected randomly, without the knowledge of HCA, but the survey was not designed to yield results that could be generalized to the HCA system as a whole. The survey can be interpreted as no more than the opinions of the 17 people interviewed.

Those interviewed were uniformly positive about HCA. They felt the company had had a favorable impact on the

In a letter to members of four county medical societies in the greater Portland area, the president of the Multnomah County Medical Society wrote, "Frankly we, like you, have grown weary of attempts by nonphysicians to manipulate and/or profit from our services; we believe that if insurers, entrepreneurs, and hospitals are so very anxious to create delivery systems for our professional services, then perhaps we ought to consider doing the same thing for ourselves and our patients."

—"Too Many Doctors," A. Voegtlin, *The New Physician* (No. 8, 1983)

quality of patient care at their facilities, as well as a positive impact on the community. They did not report any instances of attempts by HCA to influence the characteristics of the patient population or to influence the use of tests and procedures by the medical staff. The interviewees reported that patient charges at the facilities were approximately equal to the average of the community. Finally, they reported that local governing boards had significant autonomy in establishing financial and programmatic policy. This survey did not yield any information that caused the committee concern.

The committee was informed of a recent study by the General Accounting Office of the 1981 purchase of Hospital Affiliates International by HCA. This study has not yet been released to the public. The committee received accounts of the study from several sources, including HCA. This study and the possible outcomes of it were not major factors in the committee's decision concerning the proposal.

The committee wishes to thank formally all of those who collaborated with it.

Benefits of the Proposal

The key question facing the committee was whether the proposal would enhance the threefold academic mission of teaching, research, and patient care at McLean and HMS. Of particular importance was the need to balance the advantages of a major infusion of capital against the perceived effects on the attitudes and morale of the faculty at McLean, in other Harvard departments of psychiatry, at the school, and in academic medicine as a whole.

The committee identified a variety of benefits that could flow from the proposal. Many are the result of the significant financial investment HCA would make in McLean. There are other benefits, however, which are not directly financial, and which would include expanded opportunities to contribute generally to patient care, medical education, and research into psychiatric disorders. These benefits are described in the following paragraphs.

Stability of the Income Supporting Academic Activities

The economic environment facing the health-care sector has become increasingly constrained in recent years. Health-care costs have continued to grow in real terms in relation to the gross national product. Various levels of government have responded to this situation with an arsenal of different cost-containment strategies. Most of these strategies, like the new Medicare prospective payment system and the Chapter 372 reimbursement system implemented last year in Massachusetts, are aimed at constraining hospital costs and revenues. Chapter 372 is particularly worrisome because it contains no recognition of the special needs of teaching hospitals.

These frequent changes in reimbursement policy destabilize the flow of resources into hospitals and force many adjustments in both program and budget, particularly in teaching hospitals. One major advantage of the HCA proposal is that it offered to insulate the academic programs from future changes in hospital reimbursement policy.

Specifically, the proposal would establish permanent endowments to fund five professors at McLean. Such permanent appointments are currently backed by the faith and credit of the MGHC. Endowment funding would remove the financial risk of such appointments.

The proposal would also ensure that current funding from hospital operations for training and research will be maintained at no less than its present, real-dollar level. This guarantee would apply regardless of the specific financial fortunes of McLean Hospital, and would thus be an important protection for these academic activities.

Expanded program opportunities

HCA currently operates 3,800 inpatient psychiatric beds, and has plans to build or acquire 3,000 more. It operates over 350 hospitals of all types, and is the largest for-profit corporation in the hospital sector.

Until about ten years ago, most hospitals were operated as nonprofit community institutions without much regard for cost-effective management. But now private enterprise has discovered the hospital business. Says U.S. Senator Howard Metzenbaum of Ohio: "There is one business that is growing faster than the computer business – franchised medicine?"

—"Prescription for Profits," C.P. Alexander, *Time* (7/4/83)

This size and diversity offer many program opportunities for the McLean faculty. HCA has indicated its desire to contract with the McLean faculty to provide continuing education programs for the medical staffs of its other psychiatric facilities. This opportunity would probably also be open to other HMS departments. Continuing education has been an important source of discretionary income for the clinical departments, and this new opportunity would probably be welcomed.

Participation in this large network of psychiatric facilities would open new research opportunities for McLean as well. HCA has a sophisticated management information system shared by all its facilities. Access to a patient data base of this size and detail could be an invaluable asset to clinical research at McLean and in other programs, such as the Harvard program in psychiatric epidemiology. There may also be an opportunity to include patients throughout the HCA system in clinical protocols designed at McLean and other Harvard departments of psychiatry.

Finally, the role of McLean as a psychiatric referral center could be enhanced through referrals from HCA's facilities. The McLean faculty, and other Harvard departments of psychiatry, might also have expanded opportunities for consultation and liaison work at general hospitals operated by HCA.

The committee recognizes that McLean would not have to be owned by HCA in order to realize many of the programmatic benefits described above.

Access to Administrative Expertise

HCA has a reputation as a well-run company. Its corporate staff provides support in all areas of management—from accounting, to human resource management, to purchasing, to quality assurance. This rich resource of administrative expertise is a valuable asset given the rapid pace of change in the hospital industry.

HCA would also be a strong advocate for McLean in influencing regulations and legislation at the national and state levels. This political clout could be a benefit for McLean, but it also poses a major risk. It is possible that the position taken by HCA on some public issues would be contrary to the best interests of McLean or HMS. One must not assume that the interests of these three entities would always mesh harmoniously.

Strengthened Relationship with Harvard Medical School

A beneficial side effect of the proposal is that it strengthens the ties between McLean and HMS. If it endorsed the proposal, Harvard would have an even greater stake in the quality of the programs at McLean. The dean of the faculty would chair McLean's governing committee and would thus have direct responsibility for overseeing the agreement with HCA. HMS would also have greater responsibility for McLean's research programs, since it would have corporate accountability as grantee.

Access to Capital

The committee was informed that the capital needs at McLean and MGH total $250 million. The trustees of these two hospitals have serious reservations about their ability to fund this need.

The HCA proposal would not only meet the need for $35 million to renovate McLean, it would provide that capital at a much lower cost than would be available to the trustees through conventional sources. As a publicly held corporation with a favorable price/earnings ratio, HCA has access to equity capital at low cost. It is estimated that if McLean's renovation program were financed through HCA, the $35 million investment would increase the interest cost per patient day by $23. If the trustees financed the same investment with tax-exempt debt, the increased cost per patient day would be $36. The proposal could thus result in lower patient-care costs at McLean.

The proposal would also satisfy a significant portion of MGH's capital needs, since the trustees would probably use some portion of McLean's purchase price for that purpose. This benefit for MGH is an important aspect of the proposal, not only because that institution provides

The [hospital management] companies most often named as best bets [for investors] are the largest in the field: Hospital Corporation of America, Humana, National Medical Enterprises, and American Medical International. For the cautious, the logic is that if anyone is going to succeed under the new Medicare system, these companies will. And if it turns out that the big chains can do better under the new setup... this group may have only begun to tap its potential.

—"What Ails the Hospital Managers?" *Institutional Investor* (November 1983)

approximately 40 percent of the clinical instruction given to HMS students, but because it is a national resource for patient care and biomedical research.

Value as a Model

The committee believes that the proposal could have value as a model. McLean is not the first academic hospital to consider this type of arrangement with a for-profit hospital chain. Others have done so in the past and more will do so in the future as a result of increasing pressure to find new sources of support.

Despite the fact that it would not be a model for mass replication, the proposal could serve as a point of reference for arrangements between academia and industry. The proposal establishes strong safeguards for the academic enterprise which could serve as guidelines for any teaching hospital considering a similar proposition.

Risks in the Proposal

None of the risks identified by the committee relate specifically to HCA. The committee received favorable comments about the company from many sources. The risks described below would be relevant for any for-profit provider of health care.

As noted in the introduction to this report, the committee believes that many of these risks are, or could have been, safeguarded in an agreement with HCA. These safeguards are mentioned where appropriate.

Violation of Public Trust

In the eyes of many observers, the sale of McLean to a for-profit corporation after 170 years of public support is a violation of the public trust. The rationale behind this belief is complex, and was not always clearly articulated for the committee. Still, it is a belief shared by many faculty and representatives of the community.

McLean is a fine institution, among the finest academic psychiatric hospitals in the nation. It attracts top candidates to its graduate training programs and has a distinguished faculty. Even more important, McLean's research into the basic biomedical origins of mental disease has made it a major contributor to the fields of neurochemistry, neuroscience, and psychiatry, and should keep it at the forefront of these fields in the future.

McLean is the product of nearly two centuries of dedication from the psychiatrists and investigators who have worked and taught there, and the many benefactors and friends who have provided dollars and volunteer services. There is a strong sense that it is inappropriate for a for-profit corporation to benefit from this previous public and academic investment, regardless of the purchase price paid.

There is also a concern that the sale of McLean to HCA would jeopardize McLean's ability to satisfy its mission in perpetuity. HCA has been a very successful company, but it is still a young company engaged in a volatile business. It is possible that the company's goals could change.

The proposal offers some safeguards against this possibility, chiefly through a provision whereby the trustees can repurchase McLean if the agreement founders. If the committee had endorsed the sale, it would have recommended that this buy-back provision be strengthened considerably so that it would be financially feasible to execute.

The proposal has several other provisions designed to protect the public interest. The governing committee for the hospital would have majority representation from HMS and the MGHC; HCA would have minority representation. In addition, the faculty practice and research aspects of McLean would continue their not-for-profit status in corporations independent of HCA.

These safeguards are important, but many of those advising the committee did not feel they were sufficient. Many faculty members felt that the sale of McLean to a for-profit corporation would be a violation of the public

Four Massachusetts nonprofit hospitals have entered into partnerships with a fast-growing Texas corporation to open three one-day surgical centers. Medical-21, a Dallas-based company, has signed agreements with Deaconess, Faulkner, Newton-Wellesley, and Beverly hospitals to establish free-standing, profit-making "surgicenters," expected to open within six months after state approval is obtained. The proposal is controversial in some quarters, although apparently not to the same degree as the parallel trend toward takeover of nonprofit hospitals by profit-making corporations.

—condensed from "Profit surgi-centers proposed," J. Dietz, *The Boston Globe* (12/11/83)

trust regardless of the specific conditions placed on the sale.

There is another side to the public trust issue. The trustees of the MGHC have a responsibility to the public to assure the continued vitality of both the McLean and Massachusetts General hospitals. It is this responsibility that has stimulated them to examine non-traditional sources of support, such as the proposal from HCA.

Precedent Favoring the Commercialization of Medicine

Many of the strongest objections to the proposal came from those who feel that the provision of health care for profit is a destructive trend in American medicine which HMS should not endorse through an affiliation with HCA. These individuals believe that providing health care in a for-profit setting creates inappropriate incentives for physicians, alters the nature of the physician-patient relationship, and effectively reduces the healing process to a commercial transaction. These convictions clearly apply to all forms of for-profit health-care delivery.

It appears that the trend toward commercialization of medical practice is driven by many factors. For-profit delivery systems are one important causal factor, but there are others as well. Many analysts believe that the trend toward group practice, the growth of HMOs, the explosion in medical technology, and the expanding use of paramedical personnel have as much or more to do with depersonalizing and commercializing medicine as does the growth of the for-profit sector.

Many observers point out that the behaviors of for-profit and not-for-profit hospitals are frequently indistinguishable. Both are motivated to optimize net income through marketing, pricing strategies, utilization control, budget control, and other mechanisms. The difference between the two sectors is not in these objectives or methods, but in how they use the income they generate. There is also an important difference in how they respond to deficit situations, since, at least in the past, not-for-profit hospitals have rarely left the community if they experienced deficits for a few years.

Effect on Patient Costs

One of the primary criticisms of the for-profit hospital sector is that it generates profits not through greater efficiency, but through higher costs and higher charges. The committee was very sensitive to this charge in examining the proposal.

The committee's first concern was the effect of the proposed sale on patient costs and charges at McLean. The proposal itself is silent on this point. During an interview with representatives from HCA, the committee was informed that the firm would be willing to limit charge increases to no more than the percentage increase implemented at MGH. Furthermore, the firm would be willing to accept no profit from McLean for several years after the purchase and would expect an average annual return of 4.5 percent over time. This is the average return for all HCA hospitals, and the average for all hospitals belonging to the American Hospital Association. The current net income earned by McLean is greater than would be expected by HCA.

The committee would have recommended that restrictions on charge increases be stated explicitly in a contract with HCA, if it had recommended approval of the proposal.

Aside from the concern over costs and charges at McLean, the committee was concerned about HCA's national performance. The committee remains unconvinced that good, objective comparisons of cost and charge data between the for-profit and not-for-profit sectors are available. This is an issue that requires additional study and documentation.

Effect on Quality of Care

The committee was concerned that the quality of patient care at McLean could be compromised by the proposed sale. Poor quality of care is not a general criticism of the for-profit hospital chains, at least not in the studies

Unable to meet the costs of its new medical complex, University Hospital of Louisville, Kentucky, has entered into an unprecedented public/private partnership with Humana. In what it calls "a bold experiment," the corporation is leasing the complex, ensuring continued support for teaching programs at the hospital, and—with set funding from local governments—guaranteeing care for indigents and the medically needy of the county on a four-year, renewable contract.

—paraphrased from a Humana Hospital University publication

reviewed by the committee. There is the potential, though, that quality of care could be reduced if patient services were reduced to cut cost and maintain profit.

The committee is satisfied that the proposal would have addressed issues protecting quality of patient care. The medical staff at McLean would continue to hold joint appointments at HMS, and proposed appointments would be subject to the scrutiny of both institutions. The medical staff would continue to be self-governing, and would bear responsibility to the governing committee for quality assurance. Furthermore, the proposal guarantees that the current physician/patient ratio would be maintained.

One must also acknowledge that the physical plant renovations made possible through this proposal would contribute to the quality of patient care.

Effect on Patient Population and Reimbursement

McLean Hospital currently cares for very few patients (2.6 percent of gross revenue) who cannot pay for their care. The proposal from HCA guarantees that this free care would continue, but since it is so small it is not a major factor. The committee would have recommended some increase in the amount of free care if it had endorsed the proposal.

The committee reviewed data from HCA indicating that its mix of cost and cost-minus payers (the patients who do not pay full charges) is roughly 50 percent: close to the national average. The committee's telephone survey of medical staff presidents at HCA hospitals did not reveal any evidence of attempts by the company to alter payer mix.

"Skimming," or selecting for treatment patients with the best insurance and the most profitable diseases, is a common criticism of for-profit hospitals. The preceding paragraphs deal with the payer mix element of "skimming," which does not seem to offer any risk at McLean. The greater risk lies in the disease mix aspect of "skimming."

McLean treats many severely ill patients who require long-term therapy. This type of care is labor intense and expensive. The faculty practicing at McLean are concerned that some of these expensive programs will be sacrificed for financial reasons, regardless of their value by other measures.

This is a legitimate fear—one faced in not-for-profit settings as well as in for-profit settings. The proposal offers no special protection against attempts by HCA to alter disease mix. The governing committee, chaired by the dean of HMS and dominated by academic representatives, would be one safeguard. Others may have been warranted if the proposal had been endorsed.

Greater Complexity and Fragmentation

The proposal divides the current McLean Hospital Corporation into three entities: a for-profit hospital subsidiary of HCA, a not-for-profit professional practice association, and a research division under the corporate umbrella of Harvard University. This type of separation is an unavoidable consequence of operating the hospital as a for-profit entity. It shelters faculty practice and research from the control of HCA, but it also creates a new level of complexity.

The committee is convinced that this greater organizational complexity is likely to hinder patient care, education, and research. The difficult question is not "whether," but "how much." The committee heard eloquent testimony from multiple McLean representatives explaining this problem. The consensus is that the greatest damage would probably be done to clinical research, which is a fragile enterprise even in the most sympathetic setting. Resident training may also be adversely affected.

The problems of organizational fragmentation are essentially problems of competing priorities and competing authority. There is a fear that the professional and supporting staffs may no longer be able to function effectively as a team if the supporting staff is employed by a for-profit entity. These concerns are real. Unfortunately, the committee neither received nor developed any suggestions for controlling these effects of organizational fragmentation and complexity.

This turn of events [the rise of a corporate ethos in medical care] is the fruit of a history of accommodating professional and institutional interests, failing to exercise public control over public programs, then adopting piecemeal regulation to control the inflationary consequences, and, as a final resort, cutting back programs and turning them back to the private sector.

—*The Social Transformation of American Medicine*, Paul Starr (Basic Books, 1982)

As financial constraints imposed by legislative processes increase, as is predicted for the future, it will become increasingly important for the management and professional staffs of academic hospitals to share openly in the hard decisions that must be made. These issues may be more difficult to manage in a for-profit setting. This area would require significant additional thought if the proposal had been approved by the committee.

The committee examined several variations on the original proposal to see if similar benefits could be achieved without dividing McLean into multiple corporations or operating the hospital for profit. The committee was advised that, for a combination of legal and financial reasons, including the loss of tax benefits, operating McLean as a not-for-profit subsidiary of HCA was not a feasible alternative.

The committee also examined the possibility of a lease in lieu of an outright sale. This option might involve the sale of McLean by the MGHC to a new, not-for-profit McLean Corporation. This new corporation could then enter into a lease with HCA to operate McLean. Lease payments received by the McLean Corporation could be used to retire the debt for the purchase from the MGHC. HCA could still make the $35 million investment in McLean's physical plant as long as the lease term exceeded 10 years.

This option has the advantage of obviating the need for a repurchase of McLean if the agreement is unsatisfactory. The financial parameters of the agreement could be negotiated to be similar to those in the sale option. However, McLean would still be operated for profit under a lease option, and the supporting staff would still be employed by HCA.

Effect on Internal and External Perceptions

As stated in the introduction, the committee was struck and greatly concerned by the uniformly negative reaction to this proposal. The negative reactions were not limited to McLean or to the faculty of HMS. Reactions from the American psychiatric community were negative also, as were reactions from important donors, friends, and volunteers at McLean.

The reasons for this negative reaction are varied, and the committee has captured most of them in the "risks" section of this report. Regardless of its origins, this reaction is important in itself because of its effect on morale at McLean and its effect on future support from public and private sources.

Effect on Gifts, Grants, and Contracts

The new resources provided by HCA will be of little incremental value to McLean if funding from other sources declines as a result. The proposal recognizes that contributions to the hospital ($1.2 million in FY-1983) might decrease substantially if it becomes a for-profit subsidiary of HCA. The concern is that gifts and grants for research ($5.3 million in FY-1983) will also decline precipitously.

This risk could have been offset to some degree by requiring a large, up-front endowment for research from HCA, had the committee recommended in favor of the proposal.

Effect on Other Harvard Departments of Psychiatry

The proposal in its original form would have had serious destabilizing effects on the six departments of psychiatry at Harvard. These departments compete with each other for faculty, trainees, and research support, and the new resources this proposal would have generated for McLean would have changed the competitive balance.

Respectfully submitted by,

Joseph B. Martin

Joseph B. Martin, chairman,
Faculty Advisory Committee on
McLean Hospital

Not the least of the difficulties... of [medical economics] is the fact that it is unsafe to study any single problem in isolation or to assume that the problem itself remains where it was left the night before. No sooner is one end of a plank firmly under foot than the other end rises in menacing fashion; or if, as occasionally happens, both ends of the board seem to be fairly well nailed down, it is frequently disheartening to find that this particular board is utterly detached from the rest of the edifice, and that there is no place to which one may jump.

—"Medical Economics," Douglass V. Brown, *HMAB* (January 1935)

Rebels with a Cause

Many HMS alumni knights-errant have ridden off to do battle with the problems of medical economics. Some—like Bruce Sams Jr. '55, executive director of Kaiser Foundation Health Plan, and Joseph Dorsey '64, medical director of Harvard Community Health Plan—have joined alternative health-care organizations and helped them grow to become significant elements in the new medical establishment. Some—too numerous to name—are in top administrative and health-policy research positions.

Some, like Jeff Freymann '46, help make policy research possible. As president of the National Fund for Medical Education, Freymann mobilizes financial support from the private sector to fund projects that correspond to his belief that "medical education is the lever which can bring health care into line with society's changing needs and expectations."

Some, like Baldomero Garcia Jr. '80, have dealt firsthand with the effects of dwindling resources. For the past two years, Garcia has watched government funds shrink as he has worked for the National Health Service Corps in New Mexico. "I have often been under pressure to treat without the benefit of studies, and without the drug of choice," Garcia writes. "I've forced myself to sharpen my clinical acumen, but there have been many sleepless nights. I've wondered if not getting a CT scan of a woman with new onset seizure disorder would result in irreversible or fatal consequences. I've become angry when the neighbor of the same seizure patient has access to state-of-the-art medical technological advances."

Then there are those who have struck out on their own to try experiments in administering and financing health care—often to make it more accessible to the underserved. To find such innovators, we combed through years of alumni notes, watching children grow and careers progress at the flip of a card. Curiously, a number of those we found are members of the Class of '46. Among those crusaders we turned up:

- *Charles B. Beal '46, who helped develop "International Health Services, to provide various domestic and foreign health programs and services."*
- *Charles Osgood '46, who decided after medical school to serve the community in the morning, and practice internal medicine in the afternoon and evening. He has spent those mornings in a nursing home and a prison. And in 1966, with two other physicians, he "began a family medical clinic in a low-income neighborhood, a pilot project under the aegis of the Syracuse Upstate Medical Center and the Welfare Department." The clinic lasted two years, eventually folding because of administrative difficulties.*
- *George A. Saxton '46, who, "after working in Uganda, served as medical director of the Model Cities Family Health Center at the heart of the inner city in Worcester. After two years of political struggle we again retreated to try rural health center practice in Vermont."*
- *Eugene Atherton '50, who has participated in many grass-roots social organizing efforts, "particularly in the area of land-use reform and medical care in rural and ghetto areas."*
- *George L. Spaeth '59, who has "tried to develop a plan that would integrate the various health-care facilities in a community of 12,000 people: Chestnut Hill, an area of Philadelphia which was once a separate small town. We questioned just exactly what the role of a community hospital should be."*
- *Richard J. Steckel '61, who helped organize a volunteer free clinic in Venice, California, with Mayer Davidson '61.*

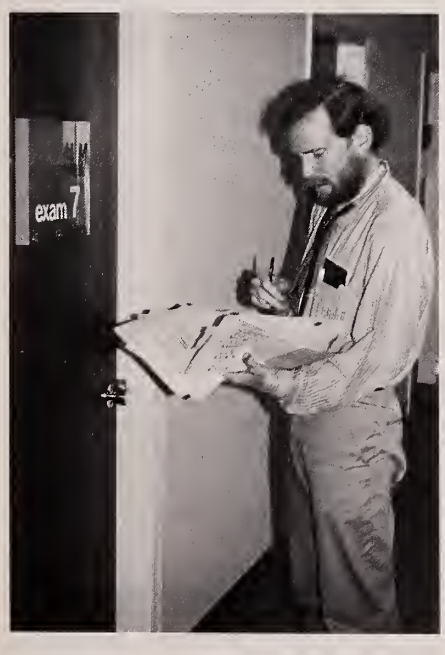
Each of the four alumni who describe their experiences below saw a need and moved to fill it. Daniel Doyle '72 has helped start and run a family health center in the coalfields of West Virginia. Johan Eliot '46 was the major clinician for the Ann Arbor Free People's Clinic, an effort initiated by health professions students. Peter Beoris '76 and his fellow emergency physicians have taken over the ownership and administration of what was part of a larger corporate emergency group. Somers Sturgis '31 was instrumental in founding the first free-standing abortion clinic in Massachusetts.

Community Medicine in Coal Country

by Daniel B. Doyle

I first came to Harvard Medical School straight from college, without taking time to think hard about why I wanted to be a doctor. Then, after the 1969 student strike, I took a two-year leave of absence to do community organizing in the Mission Hill-Parker Hill area. I worked with a community newspaper called *Good News* and with the Mission Hill Health Committee. During the second year I was an orderly at Boston City Hospital, where I discovered that I really could handle the responsibilities of helping very sick people.

I returned to HMS decided that I should practice in an underserved area—either in an inner city or a rural region. I now knew I wanted to work in a community health center with an active board—a center that was or could be tied to social action on a grassroots level. Then, during my family practice residency at University of Massachusetts in Worcester, I visited West Virginia and liked it. So when several West Virginia clinics sent a delegation to HMS and Worcester, trying to recruit doctors willing to work on salary in the coalfields, with community boards, I knew I was interested.



Daniel Doyle

> "Things continue to go well here in southern West Virginia," writes **Daniel B. Doyle**. "The New River Family Health Center, where I am medical director, is quite busy. We recently joined the Ambulatory Sentinel Practice Project of North America (ASPPN), which is an effort by 'real-world' primary care clinics to do collaborative community-based clinical research projects. We're quite excited by it. Also organizing a Physicians for Social Responsibility chapter here."
>
> —*Alumni Note, 1982*

My wife, Linda Stein, and I visited West Virginia in June 1976 and again in February 1977. We got to know Craig Robinson, a community organizer who had helped a half-dozen mining groups start community clinics in southern West Virginia. Craig told us about the Rural Practice Project of the Robert Wood Johnson Foundation. The RPP was setting up 20 "model rural practices" around the U.S. based on the concept of physician-administrator "leadership teams."

Craig and I joined forces with the New River Family Health Association, a fledgling non-profit corporation formed by representatives from three United Mine Workers local unions. The association's community board had held organizing meetings but not yet opened a clinic. Linda and I moved to Fayette County, West Virginia; Craig and I wrote a proposal to RPP and spent nine months working out the nuts and bolts of starting up practice. In June 1978, the New River Family Health Center opened its doors with a $412,000 grant from RPP.

Careful financial planning for eventual self-sufficiency was a key concept in the RPP formula. Don Madison, the RPP director, knew as we did that many rural clinics simply fold when the grant money runs out. An unpublished analysis by the Tennessee Association of Primary Care Clinics provides an explanation for this phenomenon.

First, non-profit rural clinics generally operate at low productivity. They have fewer patient encounters than private practices, with lower charges and more services per encounter, partly because clinic practitioners order fewer fee-generating procedures and tests. Second, these clinics see large numbers of indigent patients, and are often viewed in the community as "free clinics." Finally, full-time administrators, health educators, and social workers, not ordinarily found in private practices of equal or greater patient volume, push up overhead costs. So does the common practice of assuming responsibility for billing insurance, Medicare, or Medicaid.

I knew I wanted to work in a community health center with an active board—a center that could be tied to social action on a grassroots level.

We knew that we would face many of these problems. With help from the RPP staff and active participation of the NRFHC board, Craig and I mapped out a financial strategy that

we hoped would allow our health center to become a permanent community institution. We took seriously the goal of "breaking even," although 20 percent of our patients were indigent and we planned to provide health education and social work services.

We started in June 1978 with a family physician (me) and a physician assistant working in a remodeled mine-equipment repair shop. We had three exam rooms, a tiny waiting room, and a small business office. It always amazed me that people would wade through puddles on the parking lot and wait to see us in that crowded, drafty front room. But come they did, and by August 1979 we had added a second PA and another family physician.

The RPP grant was designed to cover our operating deficit for the first four years while the practice grew and, we hoped, the gap between expenses and revenue shrank to zero. None of the RPP money could go for construction, or even rent. The board persuaded the Fayette County Commission to pay for temporary space, while we searched for land and money to construct a modern, permanent facility. Craig's skill at grant writing combined with the board's lobbying brought $225,000 in grants from the Appalachian Regional Commission and the Benedum Foundation. On April 18, 1980, the board members proudly looked on as Jay Rockefeller, governor of West Virginia, dedicated a beautiful 5,800-square-foot clinic.

As in any business, we think in terms of marketing. We are committed to caring for the neediest in our community, but we must also attract those able to pay.

As the clinic grew, so did our patient population, in both size and diversity. About 20 percent are active or retired coal miners insured through the United Mine Workers plans. Another 15 to 20 percent are members of an Individual Practice Association (IPA) model HMO who use NRFHC as their practitioner. The HMO remits capitation payments to us for its members. Although our overhead is indeed higher than that of most private practices because of the additional services we provide, we lose no money on the many Medicaid and Medicare patients we see—some 25 to 30 percent of our total practice. Under the Rural Health Clinic Program enacted by Congress, we are reimbursed at cost—instead of by the usual formula—for services rendered these people. We do lose money on our private-pay patients, who are charged on a sliding scale. Many of them can afford to pay very little, so we must write off the rest of their charges.

By June 1982, when our four years of deficit financing ended, we had not achieved our "break even" goal. But we had performed much better than projected in our first two years, so nearly $150,000 of our original RPP grant remained. The Robert Wood Johnson Foundation agreed to a one-year extension of the deficit financing arrangement. We are still discussing the prospect of continued financing with the foundation.

Meanwhile, we have developed other sources of support, including a Rural Health Initiative grant from the federal government and other funding for several special projects. The state Health Department supports NRFHC's community hypertension tracking and screening and our pulmonary rehabilitation program dealing mainly with black lung and emphysema. The Maternal and Infant Health Outreach Worker program funded by Vanderbilt Center for Health Services pays for our women's health services provided by Linda, including health education and counseling for women, especially those with small children and those in high-risk pregnancies, many of them teenagers. For several years we had one or two National Health Service Corps physicians on our staff—though, during the Reagan Administration, NHSC has asked NRFHC to repay their salaries.

Our practice has now grown to three family physicians, a pediatrician, and two physician assistants. We have an enrolled practice population of 15,000 persons with 5,000 annual users and 15,000 annual encounters.

Our efforts to shrink the deficit continue. We work hard to increase total encounters and charges per encounter by adding reimbursable services such as spirometry and phar-

John D. Rockefeller IV, governor of West Virginia, at the opening of the New River Family Health Center

macy. Monthly financial reports showing total charges, total encounters, and average encounters per session by provider keep our awareness of practice productivity high.

As in any business, we think in terms of marketing. We are committed to caring for the neediest members of our community, but it is essential that we also attract those who are able to pay. We try to be sensitive to traditional community expectations about medical care, to maintain high accessibility with evening and weekend hours and a 24-hour on-call system for our patients, and to never give up the endless struggle to reduce patient waiting times. Six providers and many walk-in patients make continuity with a personal physician difficult, but we still strive to achieve it.

I have no doubt the New River Family Health Center will survive. Where we once had trouble recruiting physicians, we now know of several who would like to join NRFHC if only we had room for them. We have been extremely fortunate in the loyalty and continuity of our key people, including two physician assistants, Craig, me, and many board members. Even one of our National Health Service Corps physicians stayed with us after his term with NHSC had expired.

We have forged a stable and cooperative relationship between a nonprofessional, working-class community board, nearly all members of which are lifelong residents of Fayette County, and a group of self-directed, highly motivated health professionals, six out of eight of whom come from other states. The board sets clinic policy, monitors financial operations, and has final control of personnel, budget, and programs—though, of necessity, day-to-day management is delegated to the administrator and medical director. Although significant disagreements have arisen between the board and the professional staff, we have all learned new skills and new respect for one another in working these conflicts through.

This past November, after discussing morale, the center's deficit, and those who needed it the most, the board voted a $100 Christmas bonus for all employees—an expense of $2,000. Coal miners, carpenters, homemakers, retirees, they watch every dollar their community corporation pays out. In the seven years since they launched the New River Family Health Center, the 15 members of the board have lost none of their idealism. They still are determined that no patient will be turned away no matter how poor, that health education, preventive care, and family counseling will be provided to their community. But their seven years of success in making a dream come true and keeping it alive have resulted as much from hard-headed pragmatism as idealism.

The physicians at the New River Family Health Center all earn well below the average net income for our respective specialties. The maximum physician salary is $45,000 per year, and we have no incentive system. Yet we're economically still in the top 15 percent of all families in the U.S., a contrast that is very evident in our hard-hit coalfield area.

True, we have other priorities than maximizing our personal income: above-average time with our families, a reduced on-call schedule, a broad range of services to our community, participation in a community-oriented practice that serves as a model for our Appalachian region. But we are no less attentive to dollars than we would be if this were our own private practice.

What we are building may be a different health-care model, but the tools and materials are exactly the same. And we are determined that the model we build is one that can stand a long time. □

Collective Efforts

by Johan W. Eliot

From World War II through the end of the 1960s, medical students seemed to have gone through a rather dry, cold period as far as socially conscious activities were concerned. "Tired liberals" like me kept alive the spark of exploration and offered alternatives in the oldest progressive medical organization, the Physicians Forum, and various more sharply focused organizations, such as Physicians for Social Responsibility. But we seemed to be attracting few younger physicians.

Then, in 1970, when I returned after a sabbatical leave to my full-time faculty position in family planning at the University of Michigan School of Public Health, I found a surge of activity among health professionals, students, women's rights groups, and other political groups. Self-help groups, drug-help groups, gay rights groups, and crisis hot lines were flowering. Slogans such as "people taking control of their lives and their bodies" demonstrated growing concern about health-care standards, and care for women and the poor. I didn't use those terms, but I sympathized with the spirit behind them. In earlier years, I had done medically

A news brief from **Johan W. Eliot**: "I continue as part-time medical director, Washtenaw Planned Parenthood. My real fun is working with the Ann Arbor Free People's Clinic, exploring the possibilities of training paramedical assistants ('advocates') from amongst university students and others joined in this 'collective.' This is my fountain of youth!"

—Alumni Note, 1976

oriented draft counseling outside of my university position. Now I decided to switch to a new kind of community volunteer work.

The Ann Arbor Free People's Clinic had started during my sabbatical year—one of many "free clinics" that sprang up across the country at the time. Its title was subtly ambiguous. The word "People's" made it a political statement instead of a description. Furthermore, all the workers in the clinic were very aware that there is no such thing as a "free clinic": somebody was paying.

I joined as a clinician, volunteering at most three evenings a week. I was fascinated to see that many of the moving spirits in the clinic were medical students. It was a pleasure to have *them* pulling *me* into action. And it wasn't just medical students. There were students of nursing, public health, dentistry, dental hygiene, physiotherapy, social work, and pharmacy.

I found the turnaround among pharmacy students even more startling than that of medical students. A few years earlier, pharmacy curricula had been virtually devoid of material relating to the difficult lives of clients. The students weren't even taught about the many nonprescription baby products they would soon be selling. Now, suddenly, these students were establishing a "people's pharmacy," with extensive educational functions, a separate medications history to avoid drug duplications and interactions, and an emphasis on generics.

At first I was just one of the many physicians who took clinician and supervisory roles. Among these were a professor of internal medicine who was chair of the university's faculty assembly, one of Ann Arbor's most sought-after women gynecologists, and a pediatrician who now heads a hospital outpatient department. All were as attracted as I by the new spirit of the service. As the years went by and many of these physicians left, I became the major clinician.

We served a mixed population, mostly at the lower end of the economic scale. Many of our patients were "street people." Others were local residents who were fed up with the medical establishment. Our clinic had two advantages over more conventional facilities. First, it was free. Second, it offered streamlined service instead of the usual tangled bureaucracy, and extensive patient communication and education rather than the prevailing ethos of medical secrecy.

We accomplished these innovations through the use of patient advocates, usually in a ratio of two or three advocates to each clinician. Advocates were mostly university students, graduate and undergraduate. Their primary duty was to accompany the patient, explain and educate, and *listen*. They heard the clinician and the patient, and could sense gaps in communication and understanding by either. (Masters and Johnson use this technique of a third-party listener in their sexuality counseling. Incidentally, I first learned the value of carefully listening and talking to patients when I was at the Mayo Clinic from 1949 through 1952. The Mayo is famous for good reason.)

All the workers in the clinic were very aware that there is no such thing as a "free clinic": somebody was paying.

I was responsible for teaching advocates. Their considerable training covered some practical and theoretical aspects of the costs and content of primary and preventive medical care, and described procedures and the reasons for them. Advocates-in-training first accompanied experienced advocates as they went through the clinic process with patients. Then the trainee took over, with the experienced advocate sitting in.

The advocates progressively took on more activities. They learned to take the initial history and to establish the record with identifying information; to do simple laboratory procedures and explain them well; and to dispense as well as explain medications.

Many advocates expressed great interest in learning actual skills of examination and treatment, particularly for women. A number of public health students majoring in family planning took the initiative, and other women advocates joined in. We set up Saturday morning training sessions and separate Thursday evening seminars with considerable reading assignments. (The seminar still runs, for public health students, though the Saturday training sessions stopped when the clinic closed.) Women advocates learned to examine one another rather thoroughly, then moved on to examining patients, a step at a time.

In all, we gave training equivalent to that now received by health-care nurse-practitioners to six women, and partial training to another six (the clinic closed before they finished).

The Ann Arbor Free People's Clinic operated by consensus. Each week there was a meeting of the "collective" (meaning all who were interested or involved), at which physicians were simply equals, not hierarchic superiors. At each meeting, a different member of the group volunteered to serve as facilitator, another as recorder. Much of the talk concerned medical economics. In addition to the effort to further lower costs, increase quality, and personalize service at the clinic, the collective looked hard at the medical establishment.

When the University of Michigan, like many medical centers nationwide, received funding under the Hill-Burton Act, we recalled that the act contained a standard clause about treating poor people. The collective pressured the university to fulfill this obligation, and eventually it agreed. From then on, the clinic's telephone referral service (which operated during non-clinic hours) carefully screened callers for financial resources, and referred those who were eligible to the university facility.

One, two, or three paid coordinators carried out the group's decisions and attended to the many details needed to keep the organization working: typing, phoning, ordering, paying. Cleaning the premises was everyone's responsibility, and the coordinators exercised a bit of au-

thority here. I helped clean, too—though after an evening of seeing patients I usually had enough record review work that I was excused.

Where did our money come from? Our coordinators obtained several grants from small Michigan foundations. Some coordinators were paid minimum wages from CETA funds while they were still available. (Use of these federal job-training funds to support clinic coordinators was probably not just what the legislators had in mind, but public funds have seldom been more productively spent.) All the landlords or hosts of the clinic made major financial contributions by allowing us space at low or no rent. The Washtenaw County Health Department provided family-planning funds on a per-case basis, and supported our venereal disease treatment with cultures, medications, and a small per-case fee. As the clinic neared the end of its days and our backs were to the wall financially, it became easier for our advocates to ask for donations. Once they understood our situation, patients gave what they could—amounting to a total of $50 or $60 a night.

Some of our small funds were spent on medications, supplies, and equipment. Some went for rent. Some went for sub-poverty salaries for successive coordinators, who were notably able to counsel people about how to live on a low income, since they all did it.

The clinic had a few thousand dollars of last-ditch funds each year to pay for care for which no other source could be found. We decided how to allocate these funds at the weekly meetings. Some of these funds came from the City of Ann Arbor, whose council members were aware of the care with which the money was expended, and the extent of services secured for the needy by a few dollars in our hands.

The largest single item, consuming half our budget, got to be malpractice insurance. A physician in academia, or one who takes time out to raise children, and who carries no individual malpractice insurance, cannot afford to volunteer a few hours a week if he or she has to pay for insurance. The malpractice-insurance crisis hit full-force during the clinic's life, and was one of the factors that forced our closure. We did not "go bare," but sometimes we were insured for as little as three months at a time as carriers dropped us or foundered themselves. One of our coordinators, who had sold insurance in the past, performed a *tour de force* in keeping us continuously insured as long as we were open.

The clinic operated its telephone health advocacy service all through the years, providing health information and helping people thread the health-care maze and get to providers in the community who were able and willing to serve their needs.

The largest single item, consuming half our budget—and one of the factors that forced our closure—was malpractice insurance.

Through the years, the clinic occupied several sites and survived numerous turnovers in personnel. (A remarkable aspect of the organization was its capacity to continue and to transmit skills despite nearly 100 percent personnel turnover each year.) When I first joined in 1970, the clinic was located in four upstairs rooms of an old house in central Ann Arbor. A drug-help clinic occupied the downstairs. Occasionally a spaced-out teenager would wander vaguely up the stairs and have to be re-directed downward. I realized how crowded we were in this location when I found myself examining a patient on a piece of plywood laid over a bathtub.

We moved on in a year to much better, larger quarters, upstairs from what had been a Cadillac showroom. Here we had many rooms for examining, interviewing, and counseling, plus a modest waiting area, though patients still filled the waiting area and lined the stairway leading to it. We had to set patient loads and nightly cutoff numbers and times. The organizing efforts of medical students hit their peak here, as a dozen or so people volunteered each evening the clinic was open. Someone managed to equip a complete dental office in the back, and we had volunteer dental services for a time. Drug help functioned downstairs again, also in much more adequate quarters. Then one night a disgruntled teenage drug user touched a match to the basement, and we lost the entire building. We never got a dental clinic going again.

The University of Michigan stepped forward upon request at this time, and we operated a weekly evening clinic for two years in the gynecology area of the outpatient building—an awkward arrangement. Try as the collective did, there were bound to be some scraps and dirt left for the gynecology people to deal with in the morning. My most vivid memory of this period is of the pharmacists, who came each week with a portable pharmacy in a small trunk, like a peddler with his pack. They set up in the lobby, dispensed, took drug histories, gave counseling and directions to patients, then folded up completely and departed.

Our final location, for the last four years, was on the second floor of a downtown building whose aged owner looked benignly on liberal causes. He asked low rent from us, as well as from the Feminist Credit Union, an office of one of our best liberal state legislators, and some other liberal organizations, until his death at age 94. Then the property went into a trust. The trustees kindly but firmly moved us out and remodeled the building into modern high-rent office space.

The Free People's Clinic lost its lease and closed in early 1978. The collective—now numbering about a dozen, with a central core of about six—deliberately entered upon a year of reflection and discussion at that point. I was a participant in this group, a leader only in the sense of knowing a little bit more and having an M.D. We decided that we would not try to perpetuate the clinic in its previous form. The organization changed its name to the Ann Arbor Community Health Center, broadening and diffusing the image a little.

The collective decided to sponsor

a neighborhood clinic in a low-income area. The community council of the Bryant neighborhood south of town was prepared to respond. With substantial financing from federal block grant funds through the city council, two two-story apartments were remodeled for a clinic in a government housing project. Federal housing block grants flowed through the center as we tried to make the Bryant Clinic self-supporting. We learned about the difficulties of setting up a board of directors from the limited constituency of a small neighborhood, and about the sharply less satisfactory relations and creativity that occur in conventional hierarchical staff relations, compared to the collective technique of decision making. We "budded off" the Bryant Clinic in the midst of turmoil after a year, and it struggled on for three years before losing its lease, moving, and then collapsing financially.

Meanwhile, the Community Health Center identified a serious need for a teen health center in Ypsilanti, did a survey of high-school students' health-facility usage patterns and sexuality and contraceptive practices and knowledge. Our proposal didn't get funded, but it eventually formed the basis for a community proposal which was "approved but not funded" at the federal level. Nevertheless, it was boldly put into action by a board with very carefully selected community-wide membership, with much support from local agencies and numerous private foundations. This endeavor continues today. Its board and staff work together much more nearly on the collective basis.

When the legal status of the patient advocates changed with a new law requiring multi-purpose training for general practice physician's assistants, many of them decided to go on to other training programs to earn more formal credentials. Three are regular nurse-practitioners now. Five others have graduated from medical school. Their special backgrounds and perceptions of health care make them valuable physicians. Three entered Wayne State University School of Medicine at once. In their first year they organized a noontime special course on sexuality and women's health care for fellow students. I think you could say that the Free People's Clinic has had a ripple effect.

Aside from continuing to teach family planning at the University of Michigan School of Public Health, I remain involved with the Ypsilanti health center for teenagers. I also run a government-sponsored family-planning clinic in Jackson, Michigan.

The Ann Arbor Community Health Center, Inc., still exists as a legal entity, with an office in my back bedroom. Its only activities in the last two years have been a pamphlet helping women to evaluate abortion facilities over the telephone, and a project evaluating the cervical cap (a very old type of contraceptive device) under an Investigational Device Exemption from the FDA, with cooperation and help from the UM School of Public Health. The half-dozen students and a few of the physicians cooperating with the project are members of the collective, which meets formally once a year and confers informally over the telephone. When this project is over, the Ann Arbor Community Health Center may quietly fold its tent, but who knows? □

On Emergencies and Economics

by Peter A. Beoris

A 54-year-old woman presents to the Emergency Department with a 12-hour history of fever, cough, and obtundation. She is acutely ill, with a fever of 103° and a respiratory rate of 45. Gram stain of her sputum shows predominately gram negative diplococci with some intracellular organisms. Her general practitioner, upon being appraised of her condition and these findings, states: "Well, if she's got a gram negative pneumonia, she's going to die anyway." Perhaps he missed the point.

Some years and several hundred miles away, a 70-year-old man comes to an emergency room with fever, abdominal pain, and vomiting. His white count is 25,000; abdominal films show dilated loops of small bowel with air fluid levels. He has no family physician; the doctor "on call" to the ER suggests giving him compazine, demerol, I.V. fluids, and "send him home." Maybe he's been working too hard.

If situations like these were uncommon in rural America, there might be a lower rate of what has been described as "job burnout" among emergency physicians. But the half-competent primary-care practitioner remains a fact of life in small towns everywhere, and the youngster on duty in the ER is forced to learn to cope with his or her lack of insight.

After graduating from Harvard Medical School in 1976, and having decided that emergency medicine made sense for me, I completed a rotating internship at San Francisco

"Running around northern California, doing emergency medicine, I'm currently the president and medical director (translation: ax-man) for a small group called Valley Emergency Physicians," explains **Peter Beoris**. "Just married Robin Ingalls on August 28; **Gerald Paccione**, **James Lyons**, **Douglas Willard**, **Timothy Batchelder**, and **Steven Carney** were there. Flash was drunk. The only conclusion to be drawn from all of this is that residency training may be overrated. Real world rural medicine is an education in itself."

—Alumni Note, 1983

Peter Beoris

General Hospital. Rotators are a dying breed; there's no residency waiting at the end of that first year, and no established program (medicine, surgery, or whatever) that defines one's education. When you finish PGY-1, you've got a license and some training and know a little about a lot of things, but you are not adequately prepared for practicing rural, real-world medicine. Still, $18 an hour sounded good to me in 1977, so I went to work at Tuolumne General Hospital in Sonora, California.

Waiting for me in the ER were an 18-year-old boy with his scalp split open and a 10-year-old girl who "might have a bowel obstruction." She had a boardlike abdomen with right lower quadrant tenderness and no bowel sounds. While her lab work was being done, the ambulance delivered a 16-year-old girl from an automobile accident who presented with two blown pupils and had a respiratory arrest within 30 seconds. After placing all sorts of tubes, I found that the nearest neurosurgeon was 40 miles away. It was an enlightening first shift.

I found that my colleagues in ER medicine possessed variable degrees of training and variable skills. Our director was trained in internal medicine and had never learned that dirty wounds did better if you rinsed them out before you sewed them up. Frustration ensued, but within a year I was director of the department. Then I traveled, came back to California, directed another emergency department, and eventually became regional director for a large (35-hospital) profit-making medical enterprise.

I read in *U.S. News and World Report* recently that Arnold Relman of the *New England Journal of Medicine* feels that "when doctors see themselves as businessmen simply selling a highly technical service—that will be the beginning of the end of the profession." His point is well taken—but who, then, is supposed to manage us, if we are not to manage ourselves? Someone with an MBA? A lawyer who sees a medical need and figures out how to fill it? Doctors are legendarily poor managers of money. Perhaps they need to be better educated in business in order to be able to control their fiscal fate.

Small hospitals need to keep their emergency rooms open. ERs provide a community service, do public relations for the hospital, and generate income through use of ancillary services and admissions. But small hospitals do not have the resources required to keep their ERs staffed by competent physicians who are able to relate effectively to patients, nurses, and the hospital medical staff. And the newly trained physician who uses the ER as a way station between residency and fellowship, or private practice, will not work indefinitely in a less than opportune situation where the wages approximate those of a union plumber.

When emergency medical groups became a real phenomenon in the early '70s in the world of medical economics, they filled a void. They provided a "rent-a-doc" service, recruiting, scheduling, and (some more than others) doing quality assurance for the hospitals with which they contracted. They charged the hospital $X and paid the physician $Y. The difference constituted a "management fee," but it also contained the profits of the company. A plethora of swimming pools and yachts have been bought with dollars generated by the little guys who sewed, casted, splinted, and resuscitated in "the pit" 24 hours a day, seven days a week.

The emergency medical company for which I worked was sold by its entrepreneur-king in 1980, but the folks who purchased it didn't understand the ephemeral nature of what they bought. Contracts between a group and a hospital depend on personality and service. When a rural hospital pays somebody in San Francisco to staff its ER, hospital staff resent the "city slicker," but this resentment does not compare to the fear that a New York Stock Exchange listed company generates in the hearts and minds of small-town administrators. It seemed that every week another hospital canceled its ER contract. The group began to crumble.

The physicians in our group now have some control over their destiny instead of being pawns in an entrepreneurial world.

Out of the chaos there arose a remarkable idea: one way to cut these ongoing losses might be to sell some of the less desirable and less stable contracts to the practicing physicians. So during the next year, in a complicated "buyout" scheme whereby none of the new owners was compensated for management, a few of us formed Valley Emergency Phy-

sicians Medical Group. In June 1982 we moved into an office in Berkeley and began an adventure into the world of credit lines, cash flows, accounts receivable, lawyers, and the IRS. That adventure grows more complex every day.

Somehow, I became president and medical director of VEPMG. The group has a diffuse base of physician ownership: stock is distributed according to longevity and degree of administrative responsibility. The physicians in our group now have some control over their destiny instead of being pawns in an entrepreneurial world.

I still spend 25 to 30 hours each week working in the six emergency rooms with which we have contracts. It's important that I work some shifts in all the hospitals, not only to fill gaps in the schedule, but also to maintain relations with hospital staffs and remain aware of what's going on so that I can provide enlightened management—which now occupies the bulk of my time and energy. Most of my salary is derived from the "X minus Y" management fee that our hospitals remit to the group.

I never planned to be a businessman. But now that the group is on its own and needs to grow (lack of growth is stagnation, which leads to economic death), I find myself becoming a salesman. If the idea of a physician businessman is anathema to the editor of the *New England Journal of Medicine*, I wonder how he feels about those of us who are hucksters of the healing arts.

But editorial opinions are not important. Ultimately, even those of us who are involved in the business of emergency medicine are here to serve the patient. Valley Emergency Physicians exists because smaller hospitals in rural northern California need its services to provide quality care to the acutely ill and injured. Dozens of other organizations probably covet our contracts. Few of them would allow the practicing physicians to develop equity in the group, but perhaps even that is not so bad. As long as that patient recovers from her meningococcal pneumonia, as long as bowel obstructions are rapidly diagnosed and relieved, as long as some patients who suffer cardiac arrests eventually walk out of the hospital, we have done our job—both as physicians and as businessmen. □

Paving the Way

by Somers H. Sturgis

On April 10, 1973, the Crittenton-Hastings House in Brighton, Massachusetts, and the Pregnancy Counseling Service jointly opened the Crittenton Clinic: the first free-standing abortion center in Massachusetts. There was no protocol to follow in starting up the center. We had to feel our way.

Although elective abortions were totally outlawed in the Commonwealth before 1973, there was a loophole in a ruling of the state's Supreme Judicial Court. The ruling held that if a physician believed the pregnancy was a serious threat to the patient's physical or mental health—and if that opinion was supported by other doctors in the community—then an early abortion was acceptable.

"When, after 3 years of struggle," writes **Somers H. Sturgis**, "the Pregnancy Counseling Service with the Crittenton-Hastings House in Brighton opened the first free-standing non-profit ambulatory abortion service in Boston in April 1973, I was charged, as medical director, with all the administrative details of a brand new responsibility—for which I admittedly had no formal training. It has been a challenging experience, and both I and the Crittenton Clinic seem to be surviving."

—Alumni Note, 1976

As head of the Department of Gynecology at the Brigham—one of the subspecialties in the surgical service of Francis D. Moore '39—I was responsible for deciding which women met the legal criteria for abortions. For each case, I needed the concurrence of two psychiatrists. Because of these limitations, we could perform only one or two abortions a week. At the same time, as president of the Planned Parenthood League of Massachusetts, I was aware of the many women who called for help in terminating their pregnancies. PPL could only offer them counseling. I decided that something had to be done.

I had been involved in the Pregnancy Counseling Service since its inception. It had been incorporated as a non-profit organization in 1970 to provide legal, oral advice on unwanted pregnancy. The counseling was done chiefly by trained volunteers headed by an experienced master of social service.

In its first two years, PCS counseled a total of 14,000 women. Very few of these women qualified strictly under the state's limitations for a termination in a Boston hospital. One of PCS's first priorities was to find an acceptable local center where our clients might choose to have an abortion.

I had joined Archie Abrams, president of PCS, in a number of fruitless searches for an appropriate facility. Then in 1971, the board of directors of the Crittenton-Hastings House, a charitable home for unwed mothers, agreed to work for the necessary charter changes that would allow development of such a clinic in cooperation with PCS. The clinic was to be a model operation strictly within the limitations of Massachusetts law.

It took us more than two years to surmount the various roadblocks to our abortion clinic: changing the Crit's license after its corporation had voted to support a revision of its charter, aligning a supporting hospital (MGH), and compiling a satisfactory Certificate of Need for the facility. There were a series of public hearings for communities bordering on metropolitan Boston, and many appointments with the commissioners of health and mental health.

As medical director of the proposed clinic, I could call on no formal

The Crittenton-Hastings House

Even with our lack of experience, and inability to follow our Table of Organization to the letter, we formulated policies that are still practiced at the clinic 10 years later.

training or experience in administration. Yet somehow we had to meet various responsibilities. First, we had to find financial backing. In this and many other areas, we would not have been successful without the enthusiastic cooperation of the Crittenton board and Dr. Abrams. He persuaded the Scaife Foundation to commit $50,000 for relocating and refurbishing the surgical area, including much of the necessary operating equipment.

Our operating supervisor, Sally Hurlbut, had been in charge of the operating room at the Brigham Hospital, where I had scheduled those women who had passed the mandatory work-up for a legal termination prior to 1973. She took responsibility for ordering all instruments, with my approval. She also established a sound pay schedule for the nursing staff, based on her hospital experience.

We readily enlisted a cadre of skillful counselors who had been working without pay at the PCS office downtown. Administrative policies concerning part-time, full-time, sick leave, vacations, transportation, and holidays had to coincide with those of other employees of the Crittenton-Hastings House.

To set fees, we looked at what clinics in New York were charging, operating under that state's new liberalized abortion law. We started out charging $200 per case, which we lowered to $150 when commercial abortion centers opened in Massachusetts. We have only recently raised the charge to $175. We have always kept our fees comparable to those charged by commercial centers.

At the beginning, we paid surgeons on a per-session basis, whether there were few or many operations performed. Under this plan, surgeons would have no incentive to try to increase the number of patients. It worked well at first, when there were only six to 10 patients per session. Lately, however, 20 appointments may be made, and surgeons sometimes work longer than the morning session they had planned. Therefore, the clinic has instituted a sliding scale of payment according to the number of women who keep their appointments.

The duties of the medical director were spelled out in the Table of Organization. In retrospect, I can see that I was too busy—as well as wholly unprepared—to follow all the stipulations. The director was responsible for presenting the qualifications of any physician proposed for the medical staff to a Medical Advisory Board composed of at least one member of the staff of each Harvard teaching hospital. I do not recall that any such board was ever established. I was also supposed to arrange for its monthly meeting.

The medical director was responsible for a continuing review of records—which I never had time to do. I was required to "report in writing or orally" to a joint board of an equal number of trustees from the Crit and the PCS at the request of this board—which, as far as I'm aware, was never constituted.

Yet even with our lack of experience and our inability to follow our Table of Organization to the letter, Archie Abrams and I formulated policies that are still practiced at the clinic 10 years later. For example, we felt it important to provide counseling on a one-to-one basis. The Crittenton Clinic is the only clinic in the Boston area that continues to offer this service today.

I remained as medical director until Abrams wound down his busy obstetrical practice and was free to take over the job. I then served as chairman of the Clinic Committee, and am still a member of the Board of Trustees.

Our years of planning and preparation, and our opening just two and a half months after the January 1973 U.S. Supreme Court ruling on elective abortion, paved the way for others. There was little that the pro-life factions in the state legislature could do to delay or prevent other interests from developing several commercial abortion clinics during the next six months.

The Crittenton Clinic is still the only non-profit abortion clinic in the Commonwealth. Since it is part of Crittenton-Hastings House, its finances are difficult to evaluate, but I suspect that it covers its direct costs. The Crittenton-Hastings House itself always runs a deficit, and depends heavily on charitable contributions.

Crittenton-Hastings House is the only facility in the nation, as far as I know, that continues to be a sanctuary for women in the last few months of an unexpected pregnancy and, at the same time and under the same roof, offers women early in their pregnancy the chance to choose to terminate it after careful and sympathetic counseling. This truly remarkable arrangement has worked out well for both groups. □

A Fee for All

How Alumni Finance Their Own Care: An Informal Questionnaire

There was a time, not so long ago, when physicians never knew what it was like to be paying consumers of the services of their own profession.

Now, with the advent of third-party payers, and in the face of the realities of the medical financial climate, physicians have been learning to cope with the complexities of their own health-care coverage.

To find out what kind of coverage they use, and why, the *Bulletin* sent an informal questionnaire to one randomly selected member of each HMS class. The 42 respondents (out of 70 solicited) are scattered across the country, and represent a number of specialties. Some sent in far more information than we were able to use. Stanley T. Garber '34 enclosed a brief essay, "Freedom in Medicine: Physicians' Statement of Policy." George A. Ellsworth '68 sent a schedule of maximum allowable charges under his hospital's plan. And Lazarre J. Courtright '29 enclosed a booklet describing his ideal health-care center.

On the subject of professional courtesy, most respondents indicated their physicians charge only the amount insurance will cover, and they themselves follow suit. But they differ as to whether this practice constitutes professional courtesy. In fact, the definition of the term has become so hazy that it was impossible to tabulate how many extend it. Perhaps in part because of that ambiguity, this subject inspired many more comments than any other.

Results of the survey and groups of respondents' comments appear below. Some observations:

- Asked why they chose their plan, only four respondents mentioned being able to choose their own physicians as a factor. Yet all but three actually chose plans that do *not* limit their choice.
- None of those over 65, and only four of those under 65, had switched plans recently.
- Only two of the six who were dissatisfied or partially satisfied with their current plans indicated they may switch. Reasons for dissatisfaction included increased costs, reduced benefits, and too much paperwork. Three of the four who *had* switched plans recently cited cost as one factor in their decision.

Freedom to Choose

I chose the most advantageous federal plan permitting choice of physician.

–Philip K. Bondy '42

My plan gives access to specialists.

–W.R. Eyler '43A

I like Blue Cross/Blue Shield, as I can choose my own M.D. Some plans don't let one choose one's physician.

–Shirley Gallup '49

I have always believed a good HMO or group practice would be my ideal health-care program. Yet I am caught organizing our health care from among private or university-based physicians, primarily because the benefits provided by my spouse's employer are unbeatable, and because there is no good *HMO where I live.*

–Sheila Hafter Gray '58

I did not want medical care from Kaiser. On the Prudential plan I could select my own primary-care physician.

–Lois B. Epstein '59

As an M.D. I feel I can get top-quality care by choosing my own physician.

–Peter D. Kramer '76

A Physician of One's Own

We have been skipping around to specialists but need a good internist now.

–Lazarre J. Courtright '29

I have a physician, but being a doctor makes medical care easily available.

–A. Walter Ciani '31

The clinic acts as my physician.

–John S. Lyle '37

I suspect I am my own primary-care physician.
–Lemuel Bowden '39

Not having a primary-care physician has no influence on my choice of plans because I work in a large, multiple-specialty group, and primary-care physicians are always available.
–John R. Richardson Jr. '63

I think not having a primary-care physician makes me more flexible.
–Robert W. Steiner '72

I feel more confident knowing I can call an internist rather than a clinic nurse practitioner.
–Peter D. Kramer '76

Professional Courtesy

During my 50 years of active practice as a general surgeon, I gave my service to doctors, clergymen, and their families without charge. I have never had a professional charge from another physician. However, in recent years, physicians have accepted insurance coverage as full payment.
–Lawrence Chaffin '17

I carry Blue Cross to pay the Medicare exclusions and to avoid asking my physician friends for professional courtesy. I am always offered professional courtesy, but I use my insurance.
–Francis H. Straus '19

Physicians have the money to pay, if anyone *does!*
–Robert W. Steiner '72

Profile in Figures

What kind of health-care plan or insurance do you have?

	Over 65
Medicare + Blues	12 (75%)
Medicare + private	1 (6%)
Medicare/Medex	1 (6%)
Blue Cross alone	2 (13%)

	Under 65
Blues alone	14 (56%)
Private alone	5 (20%)
Blues + private	3 (12%)
Pre-paid plan	3 (12%)

Why did you choose this plan?
(Note: open-ended question to which many gave more than one answer)

	Over 65	Under 65	Total
Offered by employer	2	12	14
Good benefits	3	6	9
Relative cost	2	4	6
Choice of physician, or "flexibility"	0	4	4
Ideological	3	1	4
Long-term loyalty	3	0	3

Are you satisfied with it?

	Over 65	Under 65	Total
Yes	12 (75%)	23 (88%)	35 (83%)
No	3 (19%)	1 (4%)	4 (10%)
Partially	1 (6%)	2 (8%)	3 (7%)

Do you pay for your own health care, or is it a benefit of your job?

	Over 65	Under 65	Total
Self	14 (87%)	3 (11%)	17 (41%)
Benefit	2 (13%)	12 (46%)	14 (33%)
Part self, part benefit	0	9 (35%)	9 (21%)
Self/professional corporation	0	2 (8%)	2 (5%)

Did the relative cost of health-care plans affect your choice of plans?

	Over 65	Under 65
Yes	3 (19%)	13 (50%)
No	13 (81%)	13 (50%)

Do you have a primary-care physician?

	Over 65	Under 65	Total
Yes	11 (69%)	12 (46%)	23 (55%)
No	5 (31%)	14 (54%)	19 (45%)

I receive professional courtesy only to the extent that physicians' charges exceed combined payments by Medicare and Blue Shield (and usual and customary fees).

–Howard B. Hunt '27

Oh, I don't know if I receive professional courtesy. I always fill out forms. I can't tell whether the Blues pay or whether the M.D. turned in the forms. I certainly don't expect it.

–Lee G. Kendall '30

I don't expect to receive professional courtesy. The physicians now are a new breed. I always extended professional courtesy to my doctor friends and their families. It was an honor that they had the confidence and trust in me as a surgeon. At Harvard Medical School we were taught to practice by the sworn Hippocratic Oath and the Golden Rule. Have times changed?

–J. Russell Smith '32

Before insurance came out I never charged a physician or medical student. With insurance I sent bills marked 'insurance only' and expect this in return. As I was professor and chairman at a medical school, 10 percent of my practice consisted of physicians or their families.

–Stanley T. Garber '34

I expect to be charged whatever the physician usually charges, but I expect the physician to insist on collecting only what my insurance pays. This apparently is my physician's idea also.

–John S. Lyle '37

I extend professional courtesy to colleagues of long standing and their dependents, and to referring physicians. I charge many physicians half-fee. I think the whole concept of courtesy should be given the coup de grace.

–Sumner D. Liebman '38

During my 31 years of practice I was happy to extend professional courtesy to other physicians and clergy, and regularly offered dentists, psychiatrists, and plastic surgeons a substantial (25-50 percent) discount, as they did to me. Professional courtesy is a satisfying and gratifying gesture. I suspect that it is disappearing as more and more physicians become institutional employees.

–Lemuel Bowden '39

In the past, I have extended professional courtesy to physicians and their families, but in principle I oppose it. I think it is reasonable for all physicians to carry health insurance which includes physicians' fees, and that physicians should bill to the extent of insurance coverage. Whether they bill beyond that is up to them, but in certain cases I think it would be justified.

–Philip K. Bondy '42

I do extend professional courtesy. It is a privilege to care for colleagues and families.

–William W. Faloon '44

I neither expect nor extend professional courtesy. I have yet to meet a physician who does not have health insurance.

–Clifford J. Straehley '46

I have always given free treatment to other physicians and their immediate families and as a general rule have received the same consideration. Any insurance benefits applicable are given and/or received.

–Joseph C. Snow '48

Unfortunately, I rarely recieve professional courtesy. I was brought up in a medical family where professional courtesy was taken for granted. I extend professional courtesy to doctors and dentists, and expect to continue doing so. I consider it an honor.

–David W. Heusinkveld '51

It is not the practice within the University of Washington system to give professional courtesy.

–John M. Neff '60

I don't expect to receive professional courtesy any more. Other physicians told me they accept whatever is covered by the insurance!

–Yeu-Tsu N. Lee '61

I feel that we belong to a special fraternity that (outside of insurance payments) should not directly bill each other.

–Frederick L. Jones '71

I extend it, but only because it's organization policy. I am personally opposed to it, because I believe it further hampers an already strained doctor-patient relationship.

–James Reinertsen '73

I don't expect to receive professional courtesy, but generally other doctors accept insurance as I do, or in some cases nothing at all is required. This only happens with people I know personally. A new doctor generally bills us for a consultation if necessary—which is hard to believe, but happens. I usually don't expect anything for nothing from anyone, but each case is individualized.

–Andrew M. Rosenthal '75

Psychiatrists and Professional Courtesy

I found out that psychiatrists charge everybody the full price and did not extend any free care to anybody in my family when they were consulted.

–A. Walter Ciani '31

I extend professional courtesy, except to psychiatrists, who don't extend it themselves.

–Philip K. Bondy '42

I extend professional courtesy, except for what Blue Shield pays.

–Shirley Gallup '49, psychiatrist

I don't expect to receive professional courtesy from other physicians, and I extend it only on a limited basis. I think it complicates doctor-patient relationships, which are already complicated enough when a doctor has to become a patient. In psychiatry, particularly, professional courtesy becomes a Hippocratic anachronism without contemporary rationale.

–Harry L. Senger '57, psychiatrist

I extend professional courtesy for collegiality.

–Sheila Hafter Gray '58, psychiatrist

I bill physicians for the amount insurance will cover. I can afford to, because I'm salaried regardless of clinical income generated. In general, psychiatrists cannot afford to see patients for free since psychiatrists' net earnings are among the lowest in medical practice.

–Lorrin M. Koran '66, psychiatrist

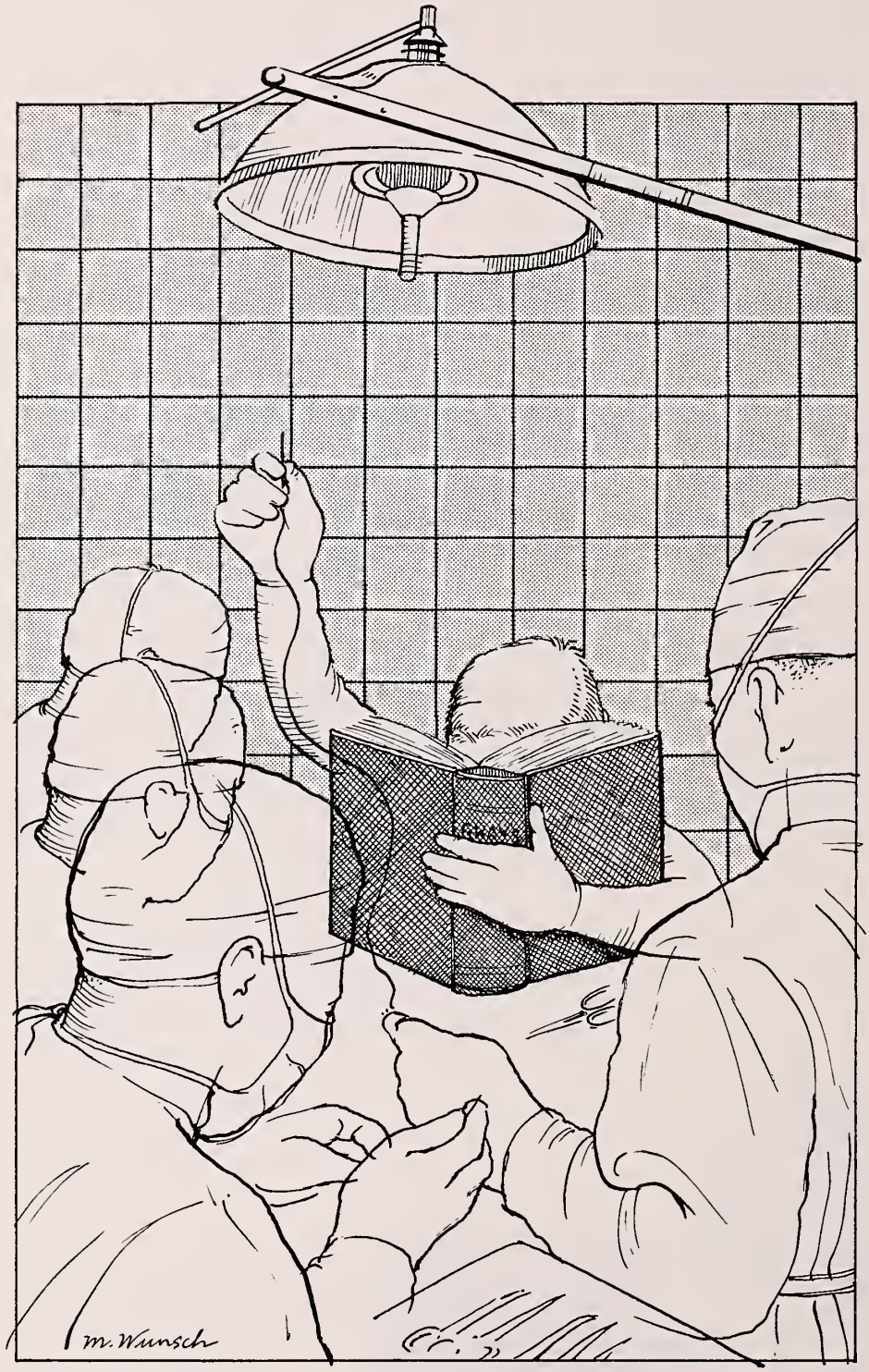
I provide an evaluation without charge. I could not generally afford to accept markedly reduced fees on several patients for treatment of any length without a significant impact on my private practice income.

–George A. Ellsworth '68, psychiatrist

I extend professional courtesy for psychiatric evaluations, but not for ongoing psychotherapy or pharmacotherapy, for the reason Freud gave: it consumes too many hours to be given free if treatment is over a long period of time.

–Peter D. Kramer '76, psychiatrist

"I used to do just medicine, but lately I've been moving into economics."



In Dreams Begin Responsibilities

Musings on an Age of Innocence

by Arthur S. Pier Jr.

The private practice of Arthur Pier '39 could be viewed as a throwback in the current medical world. Still making house calls past the age of 70, charging as little as $10 to $20 a half-hour appointment, Pier sees roughly 300 patients a month, with a caseload of up to 1,000. In a recent Boston Globe *article about his anachronistic practice, he was asked if he was disappointed that none of his three sons had followed in his footsteps. "No," he answered firmly. "In fact, I'm relieved. They call it slavery."*

Curious about the motives of a physician who so clearly works without regard to financial imperatives, the Bulletin *asked Pier to write about his past and the non-financial rewards of medicine. What follows is his response: eloquent testimony to the way things once were, and to the irrelevance of money to medicine's finest moments.*

As a member of the Class of 1939, now almost 45 years out, I have been asked to comment about what impelled me to enter the medical profession in that era long ago.

I think all of us had essentially the same motive: an ambition to enter a field which we felt would be exciting and ever challenging, to do well in it and, in the process, confer some benefit on mankind. The idea of having to earn a living through medicine hardly entered my head, nor do I recall ever hearing in my undergraduate years any discussion of the economic aspects of medicine. We were, I think, idealists then—I hope we still are—and we entered our new world with eagerness and enthusiasm.

If I had known then that my professional overhead expenses would someday exceed $42,000 a year, I might well have run away. It was the decade of the Great Depression and we were among the favored few. While our college classmates searched unhappily for nonexistent jobs, we looked ahead to four years of exhilarating study followed by more exciting years in the hospital. It would be a long time before we would have to worry about the bleak cold world beyond.

The state of the economy in those days was uncomplicated; there was

Illustration by Marjory Wunsch

no money, no inflation, and hardly any income tax. Life was simple in other ways, too. There was no PSRO, with its meticulous and unremitting scrutiny of professional services. (In spite of the importance of this tiresome organization, I can never remember what its initials stand for.) There was no URC either to speed things along and inform one's patients that their six-dollar-a-day stay in the hospital was up.

During my residency several ladies, worn out and discouraged by domestic and social responsibilities, checked in at MGH's Phillips House for an entire summer of rest. The hospital was delighted to have them, and cooperated fully in making their sojourn a comfortable one. I believe a physician gave each a complete physical examination when they entered, and perhaps one more before their voluntary departure 80 or 90 days later.

From these brief and extraneous observations, which represent all I have ever known about economic affairs, I shall turn to matters more vital and fundamental, including my own medical beginnings.

The idea of having to earn a living through medicine hardly entered my head, nor do I recall ever hearing in my undergraduate years any discussion of the economics of medicine.

◆

My father was a distinguished writer and throughout my childhood years I intended also to be a writer—a very famous one, another Charles Dickens—whose stories would rouse the world. I wrote incessantly, fervidly emulating Dickens, until I was about 12, when I began to run out of plots. A bit later, in my early teens, I came across a *Gray's Anatomy*, approximately 1880 vintage, in our house in Milton. It had belonged to my mother's father, Richard John Hall, who had been a prominent surgeon in the 1880s and 90s and who had died many years before I was born. His *Gray's Anatomy*, in spite of its venerable age, emitted an appealing medicinal aroma that is peculiarly absent from the texts of today.

I browsed about in the large volume. It intrigued me and stirred my imagination to such a degree that I determined to become a surgeon, a very great surgeon, probably the world's best. I knew little or nothing of the physician's role. Surgery was obviously where the action was, dramatic and exciting. In the course of a year or two I read about 100 pages of the *Gray's Anatomy* and felt that I was closer to being a surgeon than anyone my own age. I did have moments of misgiving, for I was aware that I lacked both mechanical inclination and manual dexterity. I assured myself that there would be time enough ahead for such details.

Brain surgery sounded like the greatest challenge of all. I would probably be a brain surgeon, a second Harvey Cushing, only more advanced. Once I got going, I would undoubtedly initiate crucial developments in the field of neurosurgery. Occasionally I would imagine myself driving at a screaming speed, escorted by squads of motorcycle police, to the scene of a fearful accident where, on the roadside, with utmost skill and nimble ungloved hands, I would promptly restore some battered brain to normal.

During the Christmas vacation of my senior year at St. Paul's School, when I was just 18, a curious event took place. My father, sympathizing with my aspirations, arranged to have the renowned surgeon Eugene Hillhouse Pool, his good friend, take me on surgical ward rounds at New York Hospital. I eagerly anticipated the occasion.

When the day arrived I spruced up fittingly with a clean white shirt, a new tie, and a blue suit reasonably well pressed. I polished my scuffed black shoes and brushed my unruly hair into a semblance of order. Above all, I cut and cleaned my fingernails. I was aware that immaculate and well-trimmed fingernails were essential for the surgeon. As I made my way to New York Hospital I felt like a dashing, sophisticated surgical prodigy. No one I knew had had an experience such as this one.

Dr. Pool was a most impressive and handsome man in his late 50s. He had a kind but penetrating look, an incisive mind, and great charm and humor. I had been told that the residents were terrified of him, for he demanded of them great efficiency, alertness, and accuracy, all qualities that he himself possessed in high degree.

"Come on, let's go," he said as he rose to greet me. He set a fast pace down the corridor to the ward. Three residents, all male and dressed in white, hastened from the far side of the ward to meet him. He introduced me to each and I gave them all a thin, cavalier smile. I wanted them to appreciate my importance as a guest of such a distinguished surgeon. Also, I wanted them to recall in later years, when my name had become a household word in surgery, their initial meeting with that singularly poised and effective young man at the very threshold of his brilliant career.

The rounds began and I tagged along. We paused at the bedside of a slender man with his left leg held in suspension. The leg was badly discolored. "This man," explained Pool, "came into the hospital and should have died but didn't, and then he should have lost his leg but didn't." I smiled approvingly at the patient and the patient smiled back.

When the rounds were over we went into an adjoining room to look at X-rays. Pool and I sat near the front. Two residents sat behind us. A third put up X-rays and commented on them. The first few films went smoothly enough but then he stalled a bit. Pool did not let him stall long. "What medical school did you graduate from?" he snapped.

"Johns Hopkins, sir," replied the resident.

"Didn't they tell you anything about Pott's fracture down there?" asked Pool.

"Oh, yes, sir," and the fracture was pointed out.

I felt rather sorry for the resident. On any ordinary day a little banter would have been natural enough, but

on this occasion, with an important visitor present, he must have felt slightly chagrined. I gave him a reassuring look to indicate that, as far as I was concerned, he was doing all right.

This session over, we adjourned to the lobby, where Pool gave instructions regarding the care of the new patients. Suddenly, to my surprise, even while Pool was talking, the resident who had shown the X-rays took a step or two toward me and murmured something. I could not hear him, so I just smiled fatuously. I thought he was probably trying to tell me something about a ward patient.

He stepped a little closer, spoke a little louder, and this time I heard. My dreams of glory vanished in the instant. I was no longer the brilliant and precocious student of surgery but an awkward and callow schoolboy, and those skillful hands that had been destined to carry me to such premeditated, unprecedented heights were turned at once to stone. The resident had spoken only three words, but they were enough. What he had said was, "Your fly's undone."

I cannot understand how this disaster could have occurred. It was scarcely a harbinger of dazzling surgical achievement.

Four years and eight months later I entered Harvard Medical School—I hope properly dressed. It soon became clear to me that I was not a born surgeon nor ever likely to be a made one. I was a poor dissector, but not as bad on the cadaver as on the living. I was timid with the scalpel, fearful of cutting too deep, and awkward with my ties. They tended to pull loose from the depths of the wound, with immediate resumption of bleeding.

One day when I was tinkering futilely in an operative wound, our dynamic instructor, peering at my handiwork, gave me a brisk swat and exclaimed jovially, "Time marches on!" I felt it would march on this way forever. I became more and more frustrated with the mechanics of surgery and with the prospect of having to be at my brightest and best at 6:30 every morning. I soon set my sights on being a physician.

I think surgery had more appeal than medicine for the majority of our class at graduation. The surgeon could do more obvious and immediate

Arthur Pier as a young man

good for his patients. The physician of that day was relatively helpless in the face of many of the diseases that afflicted the medical ward patients.

There were no antibiotics; no effective antihypertensive drugs; no corticosteroids; no chemotherapy for cancer; no dialysis machines; no coronary care units, or pacemakers, or special intensive care facilities; and no critical life-support measures beyond the oxygen tent and the intravenous infusion of saline or dextrose or blood. There was no blood bank; giving a blood transfusion was an arduous and time-consuming task. Giving several occupied a good part of a pup's day.

When I was a fourth-year student, a house officer bemoaned that the only diseases that could be effectively treated on the medical wards were diabetes and pernicious anemia. He was exaggerating slightly. Digitalis sustained some failing hearts; potassium iodide cooled off the thyrotoxic until they were ready for surgery; thyroid extract cured myxedema; adrenalin would often help the asthmatic; and arsenicals and bismuth seemed to control syphilis with prolonged administration, but not infrequently gave the patient jaundice as a dividend.

On the other hand, lobar pneumonia was often fatal, and the treatment of it with rabbit serum was extremely laborious, with often disappointing results. Rheumatic fever and rheumatic valvular disease were dreadful scourges, and bacterial endocarditis, whether acute or sub-acute, was uniformly fatal. Renal failure offered no hope. Patients with active tuberculosis, of which there were a good many, were shipped off promptly to a sanitarium.

My first patient on the medical wards when I was a fourth-year student was a 19-year-old boy, the only son of a clergyman's widow. He was most engaging and intelligent, and I became extremely fond of him. He was a heroic patient and he was frightfully sick. He had multiple subcutaneous abscesses, acute osteomyelitis of multiple bones, and staphylococcus aureus bacteremia, for which there was no specific therapy at all.

Charles Janeway kindly came from the Brigham to devote much time to analyzing samples of blood from various of us in an attempt to find blood that might inhibit the organism. A good many such transfusions were given to the boy, but all to no avail. The disease ran its inexorable and dreadful course over a period of about six weeks. We did our best to keep him comfortable and tried to sustain his spirit throughout this grim time with vigils at his bedside day and night until the sad end came. Losing him was terribly depressing. I found it a hard first lesson.

On my oral examination for medical internship at the MGH, I was asked only one question: "Can you name six diseases for which there is such specific drug treatment that it would be a crime to miss the diagnosis?" That question today would be a snap. At that time it took, for me at least, some pondering. I got through five answers without much hesitation but faltered badly on the sixth, finally coming up with "carbon tetrachloride for hookworm," which was reluctantly allowed.

"You scraped through that one by the skin of your teeth," remarked Bill Breed with a laugh as I staggered to my feet to leave the room.

Our class was fortunate in having some remarkable physicians as teachers. These men had keen diagnostic acumen, a wide knowledge of the course of disease, and they managed patients extremely well. Among the many who contributed so much to our medical education, Wyman Richardson epitomized for me the ideal doctor. I later had the honor

to be associated with him for several years before illness compelled him to retire in 1948. He was a big man in all respects, and his presence immediately lighted up a patient's confidence.

Wyman had all the qualities of a great physician: understanding, judgment, wisdom, good humor, gentleness, strength. His professional charges were meager; one of his patients once said to me, "A man of that stature could command any fee he wants." To my knowledge no patient, even the most difficult, ever left Wyman, and when, at age 51, he informed his patients that he had to retire, they wept. He was the staunchest of friends, a family doctor, a wise clinician and teacher, a gifted clinical hematologist, a naturalist, and a writer. He wrote a best seller, *The House on Nauset Marsh*, published as a book in 1955, two years after his death. During his lifetime much of it had appeared serially in *The Atlantic Monthly*.

When Wyman gave a CPC discussion at MGH, the auditorium was always packed. The Pathology Department called on him often. I have been told, though not by Wyman, that he never prepared for these discussions and never read the clinical abstract beforehand. To do so would give him an advantage over his audience. He spoke without notes in an easygoing manner and usually arrived at the correct diagnosis simply and clearly while his enthralled listeners followed him intently all the way.

He was fond of teaching, and was one of the finest teachers on the medical wards. The house officers were always delighted when his turn to visit rolled around. He had an extraordinary ability—a unique diagnostic weapon—to interpret a blood smear. He once told me that it was relatively easy to distinguish between pulmonary infection and infarction by an analysis of the blood smear. Such patients today receive lung scans and often pulmonary angiography. He did a hemoglobin and smear on every patient, taking the blood never from the finger, but always from the ear, so as to inflict no pain. On his ward visits he would always ask to see the blood smear before hearing anything about the patient's history or physical examination. His ability to crack the diagnosis, or come very close to it, on such scant evidence seemed little short of supernatural.

To my knowledge, no patient, even the most difficult, ever left Wyman Richardson—and when, at age 51, he informed his patients that he had to retire, they wept.

◆

On one occasion, after careful study of the smear, he suggested the patient might have hysteria. The slide clearly revealed to him the healthy blood of a young woman, yet she was a patient on the medical ward. To everyone's astonishment, his surmise proved entirely correct.

Only once did Wyman have to admit utter defeat. He was presented by the house staff with a blood smear of a new patient whose only noteworthy complaint was being "a little hoarse." He was not usually given even this amount of information. Wyman studied the slide for considerable time, and then confessed he had no idea what it represented, which is not surprising since it was the blood of a pet pony. He was delighted with the joke.

It is a measure of Wyman's greatness that he received little financial gain from the work he did so well. He was not a rich man, but he never dunned a patient—and he had no interest in fees beyond setting them low enough to cause no patient any inconvenience. He was most generous with his time, giving a great deal of it to medical duties that brought him little or no monetary reward. For many years he was a strong and discerning member of the General Executive Committee of MGH and chief physician of the hospital's Tumor Clinic. He was in great demand on all the hospital's wards as a consultant in hematology. During World War II, in addition to his practice and teaching responsibilities, he directed the hospital's clinical laboratory. His contributions to the hospital, to medical teaching, and to patient care were enormous.

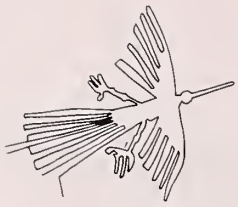
In early December 1945, Wyman invited me to share his office at 264 Beacon Street and help him with his practice—not as his assistant but as his associate. His offer was extraordinarily generous. I was able, while developing my own practice, to use his office and secretary's services the greater part of every day, and bill his patients for any service I rendered them. "The best way I can help doctors returning from the war," he remarked, "is to help one of them."

He never suggested that I pay him any rent, or help defray any of the expenses of his office. On my first day I gave him a check for $100.00, an amount that I was determined to give him each month, and which I suppose might have covered, at that time, approximately 15 percent of his office overhead costs. He accepted the check with astonishment and delight, expressed the utmost gratitude, and added, "I would never expect it to be any more than this amount under any circumstances, and if it becomes anything of a burden I would want you to make it much less."

Late one night a young staff surgeon went to one of the Bulfinch medical wards to see a patient in consultation. In the dim light of the ward the surgeon suddenly stood transfixed. He saw Wyman Richardson, the ward's Visit, with the house staff gathered near, assisting a patient who was obviously in desperate trouble.

A thoracic aortic aneurysm had given way; the patient's life was ebbing fast as blood gushed from his mouth in great bursts all over Wyman and himself. Wyman stood unflinching, supporting the patient with his arm, comforting him, soothing him, telling him that the doctors were all with him, and not to worry. The man collapsed and died in Wyman's arms. The surgeon watched all this in awe.

The house officers had called their Visit late at night when the ominous symptoms had begun. Wyman had responded immediately to sustain them and to sustain the patient. What greater inspiration can there be to medical students, house officers, or to doctors anywhere, than the example of such a physician? □



The Travel Program Of

Alumni Flights Abroad

This is a private travel program especially planned for the alumni of Harvard, Yale, Princeton and certain other distinguished universities. Designed for the educated and intelligent traveler, it is specifically planned for the person who might normally prefer to travel independently, visiting distant lands and regions where it is advantageous to travel as a group. The itineraries follow a carefully planned pace which offers a more comprehensive and rewarding manner of travel, and the programs include great civilizations, beautiful scenery and important sights in diverse and interesting portions of the world:

TREASURES OF ANTIQUITY: The treasures of classical antiquity in Greece and Asia Minor and the Aegean Isles, from the actual ruins of Troy and the capital of the Hittites at Hattusas to the great city-states such as Athens and Sparta and to cities conquered by Alexander the Great (16 to 38 days). *VALLEY OF THE NILE:* An unusually careful survey of ancient Egypt that unfolds the art, the history and the achievements of one of the most remarkable civilizations the world has ever known (19 days). *MEDITERRANEAN ODYSSEY:* The sites of antiquity in the western Mediterranean, from Carthage and the Roman cities of North Africa to the surprising ancient Greek ruins on the island of Sicily, together with the island of Malta (23 days).

EXPEDITION TO NEW GUINEA: The primitive stone-age culture of Papua-*New Guinea,* from the spectacular Highlands to the tribes of the Sepik River and the Karawari, as well as the Baining tribes on the island of New Britain (22 days). The *SOUTH PACIFIC:* a magnificent journey through the "down under" world of New Zealand and Australia, including the Southern Alps, the New Zealand Fiords, Tasmania, the Great Barrier Reef, the Australian Outback, and a host of other sights. 28 days, plus optional visits to South Seas islands such as Fiji and Tahiti.

INDIA, CENTRAL ASIA AND THE HIMALAYAS: The romantic world of the Moghul Empire and a far-reaching group of sights, ranging from the Khyber Pass and the Taj Mahal to lavish forts and palaces and the snow-capped Himalayas of Kashmir and Nepal (26 or 31 days). *SOUTH OF BOMBAY:* The unique and different world of south India and Sri Lanka (Ceylon) that offers ancient civilizations and works of art, palaces and celebrated temples, historic cities, and magnificent beaches and lush tropical lagoons and canals (23 or 31 days).

THE ORIENT: The serene beauty of ancient and modern Japan explored in depth, together with the classic sights and civilizations of southeast Asia (30 days). *BEYOND THE JAVA SEA:* A different perspective of Asia, from headhunter villages in the jungle of Borneo and Batak tribal villages in Sumatra to the ancient civilizations of Ceylon and the thousand-year-old temples of central Java (34 days).

EAST AFRICA AND THE SEYCHELLES: A superb program of safaris in the great wilderness areas of Kenya and Tanzania and with the beautiful scenery and unusual birds and vegetation of the islands of the Seychelles (14 to 32 days).

DISCOVERIES IN THE SOUTH: An unusual program that offers cruising among the islands of the Galapagos, the jungle of the Amazon, and astonishing ancient civilizations of the Andes and the southern desert of Peru (12 to 36 days), and *SOUTH AMERICA,* which covers the continent from the ancient sites and Spanish colonial cities of the Andes to Buenos Aires, the spectacular Iguassu Falls, Rio de Janeiro, and the futuristic city of Brasilia (23 days).

In addition to these far-reaching surveys, there is a special program entitled *"EUROPE REVISITED,"* which is designed to offer a new perspective for those who have already visited Europe in the past and who are already familiar with the major cities such as London, Paris and Rome. Included are medieval and Roman sites and the civilizations, cuisine and vineyards of *BURGUNDY AND PROVENCE*; medieval towns and cities, ancient abbeys in the Pyrenees and the astonishing prehistoric cave art of *SOUTHWEST FRANCE;* the heritage of *NORTHERN ITALY,* with Milan, Lake Como, Verona, Mantua, Vicenza, the villas of Palladio, Padua, Bologna, Ravenna and Venice; a survey of the works of Rembrandt, Rubens, Van Dyck, Vermeer, Brueghel and other old masters, together with historic towns and cities in *HOLLAND AND FLANDERS:* and a series of unusual journeys to the heritage of *WALES, SCOTLAND AND ENGLAND.*

Prices range from $2,225 to $5,895. Fully descriptive brochures are available, giving the itineraries in complete detail. For further information, please contact:

Alumni Flights Abroad
Dept. HMS 19
White Plains Plaza, One North Broadway
White Plains, New York 10601